ACCESSIBILITY OF MENTAL HEALTH AND SOCIAL SERVICES BY IMMIGRANTS AND REFUGEES: A SURVEY OF PROVIDERS

A thesis presented to the

Faculty of Graduate Studies

in Partial Fulfillment of the Requirements

for the Degree of

Master of Social Work

by

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Canada

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ABSTRACT

Researchers have previously reported barriers that immigrants and refugees encounter when attempting to utilize mainstream mental health and social services and have concluded that these services are often inaccessible.

This telephone census examined the perceptions of 85 management level service providers who represented 70 mainstream mental health and social service organizations in Winnipeg regarding service accessibility by immigrants and refugees. A cross-sectional design was utilized to obtain descriptive information, and compare the responses from institutional and community based organizations, as well as from the public and private sectors. Six hypotheses were tested.

The findings of the present investigation are more positive than past research although this may be explained on the basis of factors such as differential informants, temporal and geographical differences, and differences in definitions of immigrants and refugees. Overall, the respondents identified the system and organizations as being responsible for linguistic and other barriers. Most respondents indicated that immigrants and refugees have unique access problems and that mainstream services in Winnipeg were not adequate to meet their needs. The majority of respondents reported providing cross-cultural staff training and adequate networking practices with ethnospecific organizations and clergy. However, most respondents acknowledged using answering machines

and English-only telephone reception which are barriers noted in the literature.

With respect to comparisons, significant differences in favour of public over private sector respondents were found regarding planning, policies to increase access, provision of cross-cultural staff training, practices to encourage linguistic access, and system interest in increasing accessibility. Significant differences were found that favoured community based over institutional respondents regarding service utilization.

Five of the six hypotheses were partially confirmed. Significant associations were found between planning and greater service utilization, as well as between bilingual staff/access to interpreters and greater service utilization. In addition, evidence was found of relationships between managerial attitudes and decreased barriers, and between client tracking and procedures to increase accessibility. Finally, an association was found between managerial beliefs and attempts to decrease barriers. However, contrary to the original hypothesis, ethnic board membership was found to have a negative association with the formulation of plans to enhance access.

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I. INTRODUCTION

The advent of federal and provincial legislation promoting multiculturalism has heightened the need to determine whether immigrants and refugees residing in Winnipeg are being provided equitable access to mental health and social services. Legislation which addresses equality rights, as well as the preservation and enhancement of the multicultural heritage of Canadians and Manitobans, is found in the Constitution Act of 1982 and Manitoba's Policy for a Multicultural Society (Government of Manitoba, 1990). The need for illumination regarding equitable access to mental health and social services has also been encouraged by some investigators' findings that immigrants and refugees who resettle in another country have higher rates of mental disorder than those of the host population (Beiser, 1988b; Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988b).

Researchers have noted obstacles and barriers that immigrants and refugees encounter when attempting to utilize mental health services (Canadian Task Force, 1988b; Uba, 1982). Possibly the greatest barriers results from the lack of multilingual services. Immigrants and refugees are frequently unable to speak English or French in a fluent manner with other individuals in the community. Other obstacles include a lack of information on available mental health services as well as a lack of awareness of cultural differences and an insensitivity to cultural differences by service providers (Doyle & Visano, 1987).

In Winnipeg, there is a wide range of mainstream mental health and social services being provided to its residents. Concern has been raised that recent immigrants and refugees are not fully accessing these services as a result of a variety of barriers. The Manitoba Intercultural Council (1989) conducted a brief study of the obstacles which newcomers encounter when attempting to access social services in the province. This investigation provided only an overview of the situation, with the need for further consultation with the community recommended.

To date, the issue of immigrants and refugees having equitable access to mainstream mental health and social services in Winnipeg has neither been quantitatively nor qualitatively investigated. Since there are concerns regarding barriers to mental health services for this population (e.g. Doyle & Visano, 1987), as well as legislation that guarantees equality rights for all Canadian citizens (the Canadian Charter of Rights and Freedoms of the Constitution Act, 1982) there is a need to examine the current situation in Winnipeg.

The objective of this study was to establish the degree to which mainstream mental health and social service organizations view their services as culturally and linguistically accessible in relation to service delivery to immigrants and refugees in Winnipeg. A telephone survey of 85 providers of mainstream mental health and social services was conducted in order to examine issues pertaining to accessibility.

The outcome of this study was to provide descriptive information about characteristics which included the barriers to access, the various aspects of the organizational task environment which would have to be

altered in order to enhance access, and the proportion of agency clients who are newcomers. Relationships among these characteristics were also investigated, and in addition, various kinds of service organizations (i.e. public versus voluntary sector; institutional versus community) were compared.

The literature describing immigrants' and refugees' access to community mental health services indicates that issues and barriers relate to various functions of the mental health and social service organization. These issues and barriers are reviewed in Chapter II. The range of barriers identified in the literature were categorized into the following organizational activities: planning/organizational change, service/program implementation, evaluation, and attitudes and beliefs. The rationale for placing the various barriers into the present categorization of activities was to emphasize the examination of barriers from a management perspective. This type of analysis would provide managers who possess the power within the agency to make policy and procedural decisions with a systematic means to better understand how barriers can be reduced within the organization.

The methodology of the present study is described in Chapter III. It utilizes descriptive survey methodology. This methodology cannot determine causal relationships between variables, however, several correlational relationships were investigated. They are: the relationship between organizational planning and accessibility at the implementation level; attitudes toward immigrants and refugees that exist at the management level and the variety of barriers present at the implementation of services and programs level; the tracking of newcomer

clients and the effects on accessibility; multicultural representation on agency boards and effects on barriers at the implementation level; and the effects of bilingual staff and interpretive services on the utilization of agency services by immigrants and refugees.

The findings of the study are described in Chapter IV. In addition, the author discusses any generalizations from the findings of the study to other service sectors, indicates where further research was required, and proposes future directions and research needed to increase accessibility of mental health and social services to this population in Chapter V.

II. REVIEW OF LITERATURE

Introduction

This chapter provides a review of the literature in several areas that are relevant to the present study. First, federal and provincial legislation addressing human rights, multiculturalism, and affirmative action is reviewed in order to describe the policy context for the investigation. Second, a description of immigration to Canada and Manitoba is provided which includes immigration legislation, procedures, and trends.

In the third section, concepts and terms that are pertinent to the study are defined and discussed. Fourth, the mental health needs of immigrants and refugees are described, as well as the provision of mental health and social services. A discussion of etiology and epidemiology of mental illness is included.

Fifth, the barriers that hinder an immigrant's or refugee's accessibility to mainstream mental health and social services are identified. A categorization of the barriers according to organizational functions is proposed. In the last section, previously completed research surveys of mainstream service providers with respect to immigrants and refugees are examined.

Federal and Provincial Legislation

Federal legislation during the past three decades has formalized the multicultural nature of Canadian society. The Canadian Human Rights

Act was passed in 1960 and prohibited discrimination by reason of race, national origin, colour, religion, or sex. This act was followed by the Official Languages Act in 1969 which gave statutory recognition to the official status of both French and English.

Cultural diversity in Canada was given recognition in 1971 when the then Prime Minister Trudeau gave government support for Canada to be officially multicultural within a bilingual framework. Recently, Spicer (1991) convened a forum on Canada's future during which the issue of cultural diversity was discussed. Several viewpoints were presented at this forum which are indicative of current attitudes toward multicultural policies. Spicer reported that multiculturalism was perceived as divisive and as not uniting Canada. Financial support from the government was viewed by some individuals as appropriate for providing forms of integrative assistance (e.g. language training) for newcomers to Canada, but not for promoting a specific culture's identity. The issues of racism and the lack of adaptation by institutions to the demographic changes in Canadian society were also raised.

With regards to racism, Berry, Kalin, and Taylor (1977) examined multiculturalism and ethnic attitudes in Canada using a representative sample of the Canadian population and found that overt bigotry and racism were not demonstrated. These findings are discussed later in this chapter.

Friesen (1985) noted that five specific programs were identified as part of the original Government Act on Multiculturalism as follows:

1. Culture and Development: research aimed at language retention by

cultural groups.

2. Ethnic Histories: programs to produce histories of ethnic groups.
3. Canadian Ethnic Studies: programs directed at problems of ethnic studies in Canadian educational institutions.
4. Teaching of Official Languages: programs to provide assistance to immigrant children in learning French or English.
5. Programs of the Federal Cultural Agencies: these programs included the National Film Board, National Museum of Man, The Department of Indian Affairs and Northern Development, and Department of Manpower and Immigration.

In 1977, the Canadian Human Rights Act was sanctioned. It provided legal safeguards against discrimination based on race, origin, or religion. The importance of equality rights and multiculturalism became further clarified in 1981 within sections 15 and 27 of the Canadian Charter of Rights and Freedoms of the Constitution Act.

> Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination based on race, national or ethnic origin, colour, religion, sex, age, or mental or physical ability. (Section 15, p. 6)
> This charter shall be interpreted in a manner consistent with the preservation and enhancement of the multicultural heritage of Canadians. (Section 27, p. 10)

In addition, the Constitution Act (1982) sets in place a means to rectify past discriminations, and gives an individual the ability to apply to the court for redress. The Canadian Multiculturalism Act of 1988 specifies that multiculturalism is a central feature of Canadian citizenship. However, none of these acts of legislation specifically address or deal with culturally accessible mental health and social services.

Multiculturalism has been described in the report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988a) as follows:

> The official ideology of cultural pluralism where all cultures have equal status and merit in Canadian society, and none has more power than another. Multiculturalism policies promote integration, not assimilation, of minority groups into society. (p. 98)

The Canadian Task Force's perception of multiculturalism as an ideology is congruent with the dictionary definition of "ideology". For example, Avis (1982) defined ideology as follows:

> The ideas or manner of thinking characteristic of an individual or group; especially, the ideas and objectives that influence a whole group or national culture, shaping especially their political and social procedure. (p. 665)

The perception that Canada is multicultural may be seen by some individuals as overly idealistic since multiculturalism objectives have not been fully achieved in Canadian society. For example, the Canadian Task Force On Mental Health Issues Affecting Immigrants and Refugees (1988a) noted that immigrants suffer higher rates of unemployment than the general population, and are often barred from jobs because of language difficulties and discriminatory hiring practices. In addition, many immigrants and refugees who have obtained high levels of education and training in their homelands often must resort to accepting jobs in Canada that do not utilize their knowledge and qualifications.

At the provincial level, Manitoba has also been a proponent of the multicultural philosophy. During the 1970s the focus of government efforts was on the retention of arts and languages of many cultures. In subsequent years, attempts have been made to respond to more substantive issues addressing socioeconomic equality and equal opportunity in

employment.

Provincial legislation has included the Affirmative Action Program (Government of Manitoba, 1983) which ensures a fair representation of visible minorities, disabled individuals, and women throughout the Manitoba government's job classification system, and targets discrimination for elimination in civil service employment. The Affirmative Action Program as well as legislation enacted in 1985 which addressed pay equity for government employees have been geared toward eliminating systemic racism at the provincial level.

In 1990, Manitoba's Policy for a Multicultural Society formally recognized the province as multicultural. The policy contained the government's plan to pursue additional policies to ensure that the rights and freedoms of all its citizens are protected, to provide services and programs that are sensitive to cultural values and traditions, and to encourage other institutions throughout Manitoba to offer similar services. The mental health and social service needs of the immigrant and refugee population were not specifically identified in the province's multicultural policy, but specific initiatives directed at the areas of multicultural health, education, and immigrant and settlement services were highlighted. Thus, the importance of ensuring equitable and adequate services to meet the needs of immigrants and refugees will need to be advocated in future policy initiatives.

The federal legislation that has been passed over the past three decades has guaranteed human rights by prohibiting discrimination by reason of race, national origin, colour, religion or sex. It has allowed for the implementation of specific programs that support and

emphasize the cultural and ethnic beliefs of individuals and groups. At the provincial level, Manitoba has shown support for the ideological belief of multiculturalism with the enactment of its own legislation related to employment, pay equity, and to multiculturalism.

The relevance of federal and provincial legislation in facilitating culturally appropriate and accessible mental health and social services is notable but is limited in its focus. At this time, there should be additional legislation that promotes a more encompassing enforcement of the principles of affirmative action, pay equity, and multiculturalism in both the public and private sectors. If specific legislation at the provincial level was put in place, new opportunities for developing a multicultural workforce in all areas of employment, including mental health and social services would be created.

Immigration to Canada and Manitoba

Historically, Canada has been described as a land of immigrants (Dickenson, 1975). According to Dickenson, the Aboriginal people immigrated to North America over 40,000 years ago by crossing the Beringland bridge which once was connected with Asia. During the 17th century immigrants began coming to Canada from Europe and Britain, and these were considered the major source areas for immigration until most recently.

Canada's first immigration legislation grew out of the British North America Act in 1867. This legislation provided for a division of responsibilities between the federal and provincial governments regarding the immigrants' welfare and did not restrict any types of people who wished to immigrate to Canada (Smallwood, 1989). According

to Smallwood, amendments to the legislation that have ensured selective immigration policies were noted in the following years:

1872: The landing of criminals was prohibited.

1885: Restrictions were placed on Chinese immigration.

1902: The exclusion of "diseased persons" was specified and included the physically and mentally infirm.

1907: Legal mechanisms were put in place to deport those who had been admitted.

1910: The prohibited class of subversives was introduced.

1914-45: The concept of sponsored immigrant and the use of the visa to control immigration at source countries were introduced.

1947: Emphasis was placed on sponsored relatives and the repealing of the restrictions placed on the Chinese. Compulsory x-rays were required for immigration.

1952: Immigration procedures were changed to include the use of special inquiry officers to determine admissibility of certain classes of immigrants and the setting of annual quotas.

Specific humanitarian efforts have also been made by Employment and Immigration Canada to facilitate acceptance of refugees who were in need of resettlement due to fears of persecution. Filion (1990) noted some of the following refugee movements: postwar European movement (1947-53), Czechoslovakian movement (1968-69), Vietnamese/Cambodian program (1975-78), Polish movement (1982-85), and the special movements that have been in place since the 1980's related to Iran, El Salvador, Lebanon, Sri Lanka, and Guatemala.

In 1977, the Canada Employment and Immigration Commission was

established. Subsequent Employment and Immigration Canada programs have been developed which reflect a balance between labour market needs, the reunification of families, the protection of refugees, and the socioeconomic needs of Canada (Employment and Immigration Canada, 1990b). Furthermore, the responsibilities of the federal and provincial governments were specified beyond what was in the British North America Act.

The federal department was seen as responsible for determining the annual quota for immigration to Canada, establishing selection criteria, and determining eligibility of individuals seeking immigration to Canada. Each provincial government was seen as accountable for making sure that services under its jurisdiction are accessible to immigrants in order to facilitate their adaptation to Canadian life. Programs in the areas of health care, social services, education, employment, and housing were included in these responsibilities (Employment and Immigration Canada, 1990b).

The process for immigrating to Canada utilizes a category system. Manitoba Family Services (1989) provided the following descriptions of the three main classes of immigration to Canada which are family class, refugees, and independent immigrants.

> Family class immigrants are persons who are sponsored by certain relatives who are Canadian citizens or permanent residents. Refugees consist of convention refugees and members of a designated class. Convention refugees are persons who cannot return to their home country by reason of a well-founded fear of persecution. Members of designated classes are persons who are in refugee-like situations who are in need of resettlement, even though they may not meet the strict definition of convention refugee.
>
> The independent class includes assisted relatives, retirees, entrepreneurs, investors, self-employed persons, and other

> independent immigrants. Generally, applicants in this class are assessed following a point system designed to determine how well an applicant may meet Canada's socioeconomic and labour market needs and become successfully established in Canada. (p. 14)

The screening process for immigration to Canada for all three classes of immigrants utilizes procedures that enhance the likelihood of accepting only immigrants and refugees that are viewed as mentally and physically healthy. The information required from immigrants on application forms, the necessity for medical examinations and required medical tests, as well as the interpretations of verbal responses when interviewed are examples of the screening process.

During the past three decades there has been an increase of immigrants arriving from Third World countries with a decreased level coming from the industrialized world (Sheridan, 1989). There has been a preference on the part of these immigrants to settle in urban areas. With respect to the source areas, data from Employment and Immigration Canada (Colombo, 1992; Filion, 1990) summarized in Table 1 emphasizes the recent trends toward cultural diversity in Canada.

TABLE 1

IMMIGRANTS TO CANADA: SOURCE COUNTRIES
(Numbers of immigrants and percentages of total immigrants per year)

Major Source Areas	1960		1975		1990*	
Third World						
Africa	833	.8%	9,867	5.3%	13,426	6.3%
Asia	4,002	3.9%	47,382	25.6%	111,195	52.1%
Central America	1,542	1.5%	19,483	10.5%	19,459	9.1%
South America	1,823	1.8%	13,270	7.2%	8,888	4.2%
Industrialized World						
Australia	1,657	1.6%	2,174	1.2%	2,642	1.2%
Europe	82,922	79.6%	72,898	39.3%	51,667	24.2%
U.S.A.	11,247	10.8%	20,155	10.9%	6,057	2.9%

*Preliminary figures

During the past decade Employment and Immigration Canada (1989) reported that 4% of immigrants to Canada planned to reside in Manitoba. Thus, from 1980 to 1989, a total of about 43,000 immigrants intended to settle in Manitoba, with annual immigration rates fluctuating between 3,400 to 7,700.

Manitoba, Culture, Heritage and Citizenship (1991) reported the following in regards to immigration to Manitoba. The annual numbers of arrivals for the years from 1987 to 1990 were 4,799, 5,009, 6,138, and 6,626 respectively. Thus, there has been a steady annual increase in immigration. The dominant source countries during this same time period were the Philippines, Poland, Vietnam, and Hong Kong, with the Philippines being the top source country in all four years. The number of arrivals in Manitoba from each of these countries is summarized in Table 2. (The 1990 data are preliminary.)

TABLE 2

IMMIGRANTS TO MANITOBA: DOMINANT SOURCE COUNTRIES 1987-1990

	1987	1988	1989	1990
Philippines	966	821	1329	1381
Poland	410	476	355	452
Vietnam	345	355	452	479
Hong Kong	449	409	267	338

Approximately 92% of newcomers to the province in 1990 chose Winnipeg as their place of residence. The other places of destination for immigrants in this same year were Brandon (1.7%), Thompson (0.6%), Steinbach (0.6%), and Winkler (0.2%).

A further comparison of the immigration trends across Canada and Manitoba has found that the major sources of immigration during the 1980s were Asia and the Pacific Islands (i.e. Philippines, Hong Kong)

which reflects a significant shift away from the major source countries of Europe (Employment and Immigration Canada, 1989). Additional data on the trends of immigration to Canada were reported by the Social Planning Council of Ottawa-Carleton (1989). The Social Planning Council specified that in 1969, 0.6% of the Canadian population had been born in the Third World. This percentage had increased to 5.0% of the Canadian population by 1986. With regard to the future, the Social Planning Council projected that by the year 2010, 10% of the population will have been born in the Third World.

The federal government has announced its 1991-1995 immigration plan to increase immigration levels from 220,000 in 1991 to 250,000 in 1995 (Manitoba Culture, Heritage and Citizenship, 1991). In the early years of the plan, the categories of independent immigrants and assisted relatives will be maintained at current levels. However, in the plan's final years, the number of skilled workers will be increased, as well as their overall proportion. Immigrant applicants who are qualified for occupations in which there are labour market shortages will receive additional points. Thus, the new system will increase sensitivity to labour market needs.

Immigration to Manitoba between 1987 and 1990 was relatively equally distributed across the three immigration classes: 35% were in the family class, 33% were independent immigrants, and 32% were refugees (Manitoba, Culture, Heritage and Citizenship, 1991). In addition, the refugee/designated class was reported as being 35% in 1990 and was the largest category of immigration destined for Manitoba. The male to female ratio for newcomers has been essentially equivalent during the

past four years and the age ranges of immigrants have also remained constant (i.e. 25% under 16 years of age; 25% over 64 years of age).

During the 1980s the portion of all immigrants to Manitoba that had knowledge of English was between 41% and 54% on an annual basis. Fluency in one of the official languages was considerably higher for those designated as independent or family class immigrants than for refugees. The 1990 data from Manitoba Culture, Heritage and Citizenship (1991) presented in Table 3 further illustrate these differences in linguistic ability of the immigrant groups destined for Manitoba.

TABLE 3

IMMIGRATION CLASS AND LINGUISTIC ABILITY

Classes of immigration	% who know an official language
Family class	53%
Refugee (conventional and designated)	21%
Independent immigrants	65%

The above data support researchers' beliefs that a large potential barrier for immigrants and refugees is the inability to speak the receiving country's official languages in a fluent manner. However, the significance of this barrier varies by immigration class (Canadian Task Force, 1988a; Uba, 1982; Van Arsdale, 1988).

The demographic changes noted in the Canadian population will continue to have increasingly more significant effects on Canadian society. The strength and importance of ethnocultural groups will shift away from those of the European born population to those from Third World countries. These demographic shifts will increase the need for ensuring access to employment, education, health care, and to mental health and social services by immigrants and refugees. The Social

Planning Council of Ottawa-Carleton (1989) specified their concerns and stated the following with regards to the changes to the Canadian population:

> The impact of these population dynamics may be expected to place a greater strain on immigrant aid organizations, increase the need for language classes, culturally sensitive interpretation, anti-discrimination education and increase pressure from visible minority groups for access to mainstream services and participation in Canadian society. (p. 15)

In summary, the primary sources of immigrants to Canada have changed from those of European origin to individuals from Third World countries. A large percentage of these more recent immigrants are not fluent in either of Canada's official languages. In order to control the costs incurred by Canadian society related to immigration, the Canadian government has established various policies and procedures as well as an immigrant classification system which encourages the acceptance of mentally and physically healthy individuals. During the past few decades the ethnicity of the Canadian population has gradually changed to include a larger proportion of individuals who were born in a Third World country.

With respect to the future, Employment and Immigration Canada (1990a) reported that the immigration plan for 1991-1995 is to have a moderate increase (20,000-30,000 immigrants per year) of immigrants accepted into Canada for 1991 and 1992. These newcomers will be equally balanced across the family, independent, and refugee categories. There will be no additional increases in annual immigration for the rest of the planning period. Moreover, the federal government's commitment is to emphasize family reunification, increase the proportion of skilled workers accepted under the independent immigrant status, and focus on

immigrant integration into Canadian society. Given the change in demographics and the proposed plan for immigration in the following years, the need for providing English or French language classes to recent immigrants as well as providing culturally sensitive services will be viewed as greater priorities in the future.

Definitions

In this study, a variety of terms must be defined and discussed. Penchansky and Thomas (1981) noted that the concept of access has not been well defined in research and is difficult to differentiate from the terms availability and acceptability. For the purposes of this study, "access" was defined as the structural and organizational arrangements that facilitate an individual's ability to participate in a program or service (Rossi & Freeman, 1989) and includes the concepts of client and organizational access (Doyle & Visano, 1986).

Client access was defined as the extent to which consumers are able to obtain needed services which the organization provides. On the other hand, organizational access referred to the extent to which members of diverse cultural groups are represented on an agency's governing board and participate in the planning, development, delivery, and administration of services. The concept of organizational access as defined was not applicable to public (government) bodies which do not have boards, and therefore these public sector respondents were not included as part of the analysis regarding organizational access.

Doyle and Visano's description of organizational access leads one to assume that having diverse cultural backgrounds within an organization will facilitate cultural appropriateness of the service

being provided. If this assumption is correct, the extent of immigrants' and refugees' participation in treatment, as well as their rates of premature termination of service should also be affected.

In addition to examining the concept of access, the meaning of "barrier" also required definition in this study. Researchers have defined "barriers" in terms of the following attributes: availability (awareness and location of services), accessibility (narrowly used to refer to the ease of getting to services), acceptability (related to stigmatization), and affordability (monetary cost to client) (Stefl & Prosperi, 1985). Moreover, Doyle and Visano (1987) grouped barriers into categories of informational, physical and geographic, cultural, administrative, and cost.

For the purposes of this investigation "barrier" refers to something that separates or keeps apart, checks or impedes progress, is not necessarily impassable, and may include physical objects or be circumstantial in nature (Avis, 1982). In this study the presence of barriers was assumed to decrease accessibility to an organization's services. The barriers that were examined were categorized into the organizational functions of planning, service program implementation, evaluation, and managerial attitudes and beliefs in order to emphasize a management perspective in understanding how barriers can exist and be subsequently reduced within the organization.

Gallagher (1987) reviewed the prominent definitions used by researchers to interpret the term mental health and found that none of these definitions were solely sufficient. The various definitions included an individual having an absence of a disorder, an adequate

adjustment to the environment, a correct perception of reality, and a unity of personality. Gallagher concluded that it is impossible to establish a universal definition of mental health across cultures as a result of the lack of agreement about the components of "normal behaviour".

In Canada, a definition of "mental health" has been provided by Health and Welfare Canada (1988) and is the one that was chosen for use in this study as it is comprehensive and coincides with the study's objectives. The definition emphasizes the interrelatedness of society, the service system, and the mental health of the individual and is as follows:

> Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality. (p. 7)

In this study, "mental health and social services" was defined as that class of mainstream institutions and community-based programs that provide assessment, counselling and/or treatment services to meet the mental health and social service needs of its client population. The description of "mainstream" and "ethno-specific" by Doyle and Visano (1986) was utilized for this study. They described mainstream and ethno-specific services as follows:

> Mainstream was seen to refer to those organizations that offer services to everyone in the community that meet general eligibility criteria, not based on membership in a particular cultural or racial group, while ethnospecific refers to those organizations that provide services to people on the basis of general criteria which emphasize membership in a particular cultural or racial group. (p. 208)

Since the focus of the present study was to examine issues related to accessibility to mainstream mental health and social services to the immigrant and refugee populations, parameters were placed on what constituted an immigrant and refugee. The following definition for immigrants and refugees was utilized in the survey conducted with mental health and social service providers:

> Any individuals who have entered Canada during the past decade under any of the three immigration classes of family class, independent immigrants, and refugees as specified by Immigration Canada. These persons would have not spoken English or French at the time of their immigration into Canada. Furthermore, individuals whose classification had not yet been determined by Employment and Immigration Canada, such as a claimant, would also be considered for inclusion into this definition.

It should be noted that claimants are allowed access to a community's health and social services in some circumstances for humanitarian reasons, but these require the approval of Canadian immigration authorities. This definition for immigrants and refugees was developed in order to provide clarity for the respondent as it was assumed that some mental health and social service providers might not distinguish between the various classes of immigrants. In addition, the limitations of a) entry during the last ten years and b) not speaking English or French at the time of entry avoided the inclusion of immigrants and refugees who have assimilated into the mainstream Canadian culture.

Mayer's (1985) definition of planning as a process of public decision making was utilized in this investigation. He viewed planning as a rational course of collective action chosen and designed to achieve a future state of affairs. Variables measured in the planning domain included those plans developed in the areas of policy, service implementation, staff training, community networking and evaluation.

Organizational access was also a variable in the planning domain as the inclusion of members of diverse cultural groups on an organization's board relates to planning in the policy area.

Within the second domain of service program implementation, the three variables addressed were barriers (as defined previously), client tracking, and availability of bilingual and interpretive services. The variable of client tracking was described as the presence within the organization of a means of determining whether clients served are immigrants and refugees. The variables relating to bilingual staff and interpretive services were defined as an organization with staff who: speak two or more languages (including the English/French combination) and/or have ready access to qualified interpreters to assist in working with immigrants and refugees. The inclusion of the English/French combination in "bilingual staff" may place limitations on the findings reported with regard to immigrant and refugee access to bilingual services.

The third domain in the investigation was evaluation. Rossi and Freeman (1989) described evaluation as being of the following three major types: the analysis of new interventions, the monitoring of program implementations and the assessment of established programs. Evaluations do not necessarily need to be comprehensive in nature but can be more narrowly focused to concerns related to the monitoring of a plan and determining the net effects of an intervention.

The fourth domain in this study was the attitudes and beliefs of the respondents toward services to immigrants and refugees. The definition of attitude as provided by Dillman (1978) was employed in

this study. Dillman described "attitude" as follows:

> Attitudes describe how people feel about something. They are evaluative in nature and reflect respondents' views about the desirability of something. (pp. 80-81)

The definition of belief as described by Dillman (1978) was also utilized and refers to what a person thinks is true or false. Beliefs deal with what one thinks exists or does not exist, and can include an individual's knowledge of specific facts. In addition, there is no implied goodness or badness in beliefs.

Mental Health Needs of and Services for Immigrants and Refugees

When addressing issues related to the concepts of mental health or mental illness, researchers have noted a number of concerns. As specified earlier, Gallagher (1987) found there was no sufficient definition for either concept. Furthermore, there are cross-cultural differences in how various types of behaviour are viewed. For example, aggressive behaviour in an individual may be accepted to a greater extent in some cultures than in others, and thus there may be disagreement about the need for mental health intervention.

Gallagher (1987) concluded that research has consistently shown that both the etiology and epidemiology of mental illness are frequently linked with social influences. He noted that of all social influences, "those within the nuclear family are most frequently responsible for mental illness" (p. 5). The lack of a mother figure in a child's life would be an example of this influence.

The mental health needs of immigrants and refugees should be viewed in the context of the epidemiology of psychiatric disorder in the

general population. Epidemiology is usually defined as the study of the distribution of diseases in populations and of the factors that influence this distribution (Bland, 1988). The methods used in epidemiological research generally focus on the investigation of clinical aspects of disease and etiology, and on the planning of health services. Research conducted on North American and European populations have found estimates of current functional psychiatric disorders as being between 16 and 25 percent of the population (Bland, 1988).

Similar findings were reported by Bland, Newman, and Orn (1988) in relation to current psychiatric disorders in their study of epidemiology of psychiatric disorders in Edmonton, Alberta. They determined the six-month prevalence rate for all core psychiatric diagnoses as 17.1% of the population. The six-month prevalence rate refers to individuals who met the criteria for a disorder and exhibited symptoms in the six months prior to the study. Racial and ethnic data were not collected in this study.

The Ontario Child Health Study (OCHS), conducted in 1983, was a cross-sectional community survey of Ontario children between the ages of 4 and 16 years, which investigated the prevalence of psychiatric disorder, risk indicators, and mental health service utilization (Offord, Boyle, Fleming, & Blum, 1989). Risk indicators were variables that identified those at increased risk for a variety of outcomes but did not necessarily cause an increased prevalence of a given outcome. Offord et al. (1989) found that the six-month prevalence of one or more of four psychiatric disorders (conduct disorders, hyperactivity, emotional disorders, and somatization) for this childhood population was

18.1% Chronic medical illness in the child, single parent status, living on social assistance and residing in subsidized housing were all found to be strong risk indicators of increased rates of psychiatric disorders in children. In addition, specialized mental health and social services only reached one of five children considered to have a psychiatric disorder.

Other researchers have also studied the effects of a variety of risk factors on psychiatric status. As in the aforementioned Offord et al. study, poverty was one risk factor that has been found to be associated with a psychiatric diagnosis. Bruce, Takeuchi, and Leaf (1991) found longitudinal evidence from an epidemiologic catchment area (ECA) study in New Haven that individuals who met poverty status guidelines in the United States were at an increased risk for new episodes of psychiatric illness. The status of poverty was reported as being more prevalent among women, older persons, and black individuals. Bruce et al. found that since 1980, the percentage of adults living in poverty had not changed significantly but that the availability of state-financed mental health services had decreased for low-income individuals.

Given the variety of social risk factors that can affect an individual's mental health, as well as the statistical estimates of psychiatric disorder noted in research studies, it is clear that many different types of people within a given society will require psychiatric assistance. As a result, some individuals requiring assistance from mental health service providers will be immigrants and refugees.

It should be noted that immigration itself is stressful, and when certain contingencies occur as a part of the migration experience, they increase the risk of mental disorders (Canadian Task Force, 1988b). These contingencies include:

1. decreased personal socio-economic status following migration.
2. inability to speak the host country's languages(s).
3. separation from family.
4. lack of a friendly reception in the host country.
5. isolation from others of a similar cultural background.
6. trauma or prolonged stress prior to migration.
7. being an adolescent or senior at the time of migration.

Additional contingencies surrounding migration and resettlement that were identified by Milne (1990) include employability and the quality of preparation for migration. Milne reported that both unemployment and underemployment lead to significant stresses for immigrants and refugees.

The Canadian Task Force (1988b) concluded that the factor pertaining to decreased socio-economic status appears to be of central importance in determining emotional well-being. In Canada, a study of immigrant incomes completed in 1986 by Verma and Basavarajappa (cited in Canadian Task Force, 1988b) indicated that while male immigrants on the whole have higher incomes than non-immigrants, immigrants from developing countries have lower than average incomes. Overall, however, it appears that it is the relative socio-economic status (the difference between the status following migration and that recalled from the homeland), and not the absolute socio-economic status, that is most

essential to mental health (Canadian Task Force, 1988b; Quan, 1987).

It should also be noted that immigrants and refugees tend to underutilize community mental health services (Canadian Task Force, 1988a). There is also some evidence of an elevated need for mental health and social service assistance by this population (Canadian Task Force, 1988a). For example, researchers have noted the lack of preparation of refugees prior to leaving their homelands including inadequate financial resources and loss of important interpersonal relationships which can result in depression and anxiety (Stein, 1986; Lin, Masuda, & Tazuma, 1982).

However, researchers have noted that there are contradictory findings of both increased and decreased rates of psychiatric disorder and hospitalization for immigrants and refugees in comparison to the general population (Canadian Task Force, 1988b; Gallagher, 1987; Monroe-Blum, Boyle, Offord, & Kates, 1989; Quan, 1987). Quan (1987) noted that refugees experience more distress than the general population which was supported by Beiser (1988a) who found some refugees experiencing higher rates of depression than was expected. Monroe-Blum et al. (1989) reviewed six studies which had investigated the psychiatric adjustment of immigrant children and noted that, despite methodological differences, the studies had found an increased risk of some disorders for specific groups of immigrant children. Disorders which had been addressed in the studies included conduct disorder, elective mutism, and infantile autism. In contrast, the results of Monroe-Blum et al.'s own study were that immigrant children were not at increased risk for psychiatric disorder in comparison to non-immigrant children.

Gallagher (1987) also suggested that it is not always possible to compare the results of epidemiological studies, and thus research findings which draw on multiple studies should be interpreted with caution. Two sets of research findings may not be comparable because the investigators had used different concepts of mental illness and/or different methodologies for measuring the disorder(s). For example, Monroe-Blum et al. (1989) reviewed epidemiological studies of children and found that methodological differences such as definitions of "immigrant", sampling procedures, and diagnoses were apparent. Gallagher (1987) also found that treatment rates were a function of the availability of treatment facilities, public awareness of the facilities, and the attitudes of the public and treatment providers. Furthermore, researchers who have relied on admission rates to hospitals to determine prevalence rates have been handicapped as hospital records often only provide the total number of admissions and do not account for multiple admissions of patients. This also affects research on hospitalization rates of immigrants and refugees.

Humm-Delgado and Delgado (1986) felt it was important to consider the four concepts of social need as proposed by Bradshaw when addressing underserved ethnic groups. These four concepts of need are normative need, felt need, expressed need, and comparative need. Each of these concepts of need has its limitations for determining need which should result in service consumption. Normative need specifies that people lack services according to a standard of adequacy set by some expert (e.g. administrator or professional). This imposes a value judgement on the part of the expert and may not be consistent with a client's

culture, whereas felt need is essentially equated with want. Felt need can be biased by the immigrant's knowledge of available services. Expressed need is felt need turned into action by the client through attempted service utilization. Humm-Delgado and Delgado noted that language and cultural barriers can be a deterrent to expressing needs.

Finally, comparative need is determined by comparing unserved people with those who have similar characteristics but who have received services. Comparative need can also be inaccurate as it assumes that the characteristics identified are correlated with need and that there are similar needs in different cultural groups (Humm-Delgado & Delgado 1986). It is also important to recognize that culture is not static, and that changes in an immigrant's or refugee's culture will affect the assessment of his/her needs.

When examining these four concepts of needs as they relate to service planning for the immigrant and refugee population, it is important to recognize that no one concept should be given priority as each has its limitations. Possibly the best approach to planning service delivery would be for each organization to ensure that there is adequate representation at the planning level of an agency's services by all cultural groups in the community. Furthermore, it should be expected that all members involved in the planning process understand the four concepts of need as previously discussed. Planners also should understand the demographic patterns of the immigrant and refugee population with regard to the rate of population growth, migration and dispersal patterns, age concentrations, patterns of service utilization, and barriers to service (Humm-Delgado & Delgado, 1986).

Immigrants and refugees have a variety of mental health needs. Often these individuals have experienced past traumas and/or are having difficulty understanding the values and beliefs of Canadian society which may not be consistent with their own cultural beliefs.

Refugees have often experienced traumas in their lives related to leaving their homelands. Stein (1986) reviewed Kunz's kinetic model (originally published in 1973) which described the differences between immigrants' and refugees' decisions to leave their countries. Specifically, immigrants are viewed as "pulled" or attracted by opportunity to a new country, whereas refugees are "pushed" out of the country in which they wish to remain.

Refugees, before being forced out of their homelands, are generally considered functional, independent, and often successful residents within their country (Stein, 1986). The rationale for leaving their homelands and the preparations made when emigrating can be different for refugees and other immigrants. According to Stein (1986), Kunz's model depicts the flight and settlement pattern of most refugees as corresponding to the two kinetic types referred to as anticipatory refugee movements and acute refugee movements. Anticipatory refugees perceive danger in their countries before the occurrence of a national crisis. These refugees are able to leave their homelands with their entire families intact, with some personal and financial resources, and with some assurance that they will be accepted by another country. However, they differ from immigrants as they do not wish to leave their country, but must vacate because of crisis events. The anticipatory refugee is described as educated and as generally well-off prior to

emigration.

The acute refugee movement comprises those refugees who flee their countries en masse as a result of war or political crisis. These refugees have not made any preparations to leave their homelands and perceive their lives as in immediate danger. The acute refugee who has successfully left the country eventually experiences a state of shock which Kunz describes as "midway to nowhere" (Stein, 1986). This point in the refugee's life is stressful and forces him or her to consider three possible choices regarding his or her future: to return home, to remain in the place of asylum, or to accept a resettlement opportunity in a foreign land. Pressure is placed on the refugee from the country of asylum as well as from the international aid agencies to decide between these alternatives. The pressure which the refugee experiences is exacerbated because all of the options available are perceived as unsatisfactory in some respect.

Some of the post-traumatic stresses which refugees experience are a loss of status, language difficulties, poverty, unemployment/underemployment, isolation, and concern for loss and separation from families (Stein, 1986). Other post-migration variables related to immigrants' adjustment include the nature of national and provincial policies on immigration and being able to resettle in areas where there are members of one's own cultural group (Canadian Task Force, 1988b).

Refugees with a higher risk for mental health related problems are those who are single, divorced, widowed, separated from families, living in rural areas, or who are unemployed (Stein, 1986). Immigrants who

have a better chance for adjusting to a new country are those who reside in an intact family, have young children, and who are provided community support in language and job training programs in order to secure employment (Canadian Task Force, 1988b; Stein, 1986).

Lin, Masuda, and Tazuma (1982) noted that there are several sources of stress which the refugee experiences when attempting to adapt to life in the receiving country. Some sources of stress are the loss and grief connected to the separation or death of family members, as well as the loss of personal properties, investments, and interpersonal relationships with friends. Additional stresses include the feelings of social isolation, status inconsistency (i.e. loss of established social role and status), culture shock, effects of acculturation (e.g. conflicts with fundamental value orientations), coping with gaps in the level of modernization between societies, and being of minority status.

The Canadian Task Force (1988a) also noted that many refugees have been exposed to varying degrees of torture prior to leaving their home countries. Since the goal of torture is to destroy the individual's personality, this population of immigrants will likely have a great need for assistance from mental health providers, as well as general support from Canadian society.

The assistance being provided by mental health and social service providers may not always be appropriate for immigrants seeking help. Researchers have found that some immigrants and refugees have difficulties conveying their sensations of mental disorder to mental health service staff. These clients may demonstrate apparently bizarre behaviour related to a common human experience (e.g. death) and

subsequently be misdiagnosed by professionals (Canadian Task Force, 1988a; Lin, Masuda, & Tazuma, 1982).

Thus, there are certain aspects that should be considered when examining the needs of immigrants and refugees. As noted earlier, Employment and Immigration Canada has determined the status of immigrants as being of three types (i.e. family class, independent class, and refugee). This method of classification can become a detriment to understanding the plight of each type of immigrant if it is assumed that the needs of all immigrants are the same. The stresses that an immigrant experiences can be vastly different within and between each type of immigration class. As a result, the assistance that is needed from the receiving country will vary in terms of both urgency and length for individual immigrants. Some immigrants and refugees have experienced considerable trauma prior to and during their exit from their homeland. Traumas such as torture and being forced to flee a country result in lack of preparation for the immigration process and subsequent post traumatic stress.

As detailed earlier, the enactment of federal and provincial legislation makes it a responsibility to provide services in general to all Canadian citizens in an equitable manner. However, these acts of legislation cover equality of treatment under the law and do not appear specific to the provision of health and social services. In this regard, Sheridan (1989) emphasized that the application, administration, and enforcement of the law depends on judicial interpretation and legal precedents that may occur in the future.

The idea of creating "parallel" mental health services for each

ethnocultural and linguistic group in Canada has been suggested but is not seen as feasible given the need for additional resources and funding (Canadian Task Force, 1988a). Van Arsdale (1988) also stated that services to refugees should be provided through mainstream service systems in order to avoid problems related to the isolation of services. Uba (1982) found that research did not favour any one form of service delivery (i.e. mainstream facilities; special units in mainstream facilities; segregated facilities) as there are advantages and disadvantages to each. Uba concluded that the form of service provided would depend on environmental conditions that exist in a given population. These conditions include the size of the mental health organization, the proportion and/or concentration of immigrants in the population, and the extent of financial, spatial, and personnel resources.

In most provinces in Canada, the social service delivery system is composed of two systems consisting of generic services and categoric services (Hanning, 1987). Generic services respond to the social and individual needs of the population in general, whereas categoric services respond to the needs of a certain target group. In Manitoba, the special needs of immigrants and refugees are generally dealt with by generic services, as categoric services do not have the mandates nor funding to establish parallel services for this group. However, there are some exceptions, such as settlement services and immigrant serving agencies.

The establishment of ethno-specific services may be seen as practical when a geographical area has a critical mass of immigrants and

refugees from homogeneous cultural groups. In Winnipeg, this situation does not exist. In Manitoba's Policy for a Multicultural Society, the Government of Manitoba (1990) emphasized a preference for providing mainstream services rather than parallel services to its residents. The Manitoba government indicated that it intended to work to provide services and programs that are culturally sensitive and encouraged other institutions in the province to follow suit.

Manitoba Health has highlighted a mainstream approach to service delivery and has included in its fundamental principles that access to mental health services is a right of all citizens in the province and that these services shall be culturally sensitive (Manitoba Health, 1990).

Barriers to Access According To Organizational Function

An individual's ability to access an organization's services can be facilitated or hindered by the extent to which the management level staff and/or an agency's governing board have dealt with potential barriers to service at the planning, service program implementation, and evaluation levels. Essentially the board and management personnel are in control of how these levels are directed and implemented. Efforts that deal with barriers to service at one level can affect the barriers present at another level.

Agency efforts initiated at the planning level may lessen accessibility barriers at the service delivery level. For example, researchers have noted that the lack of qualified interpreters at mainstream mental health agencies hinders the immigrant's ability to access these services (Quan, 1987). Moreover, Hoang and Erickson (1985)

reported that it can be difficult to find an appropriate interpreter for each client given that some languages can have several dialects. Line workers at an agency may also experience frustration when providing services to immigrant clients and can make attempts to lessen accessibility barriers by increasing contacts with immigrant serving organizations and by enroling in workshops emphasizing cultural awareness.

Since management personnel have the responsibility to hire staff who are qualified to meet the needs of their clients, planning activities should ensure access to staff or interpreters who can speak a client's language. Networking with other community agencies and ethnocultural organizations with respect to the coordination of interpreter services, as well as setting goals to hire multilingual staff who have appropriate qualifications, would be planning strategies.

The lack of effective outreach efforts by mainstream mental health service providers can also limit access by immigrants and refugees to their services. Attempts to reach immigrants and refugees are hindered when information used by these organizations is provided to the general public in only English or French (Doyle & Visano, 1987). Humm-Delgado and Delgado (1986) noted that there is a lack of public service radio and/or television announcements describing community services in languages other than those that are dominant. The Canadian Task Force (1988a) indicated the importance of outreach services and acknowledged in their report that there is a lack of funding directed toward outreach efforts.

Doyle and Visano (1987) indicated that "mainstream and ethno-

specific service organizations exist in a state of 'two solitudes' - existing side by side but separate" (p. 15). They suggested that mainstream and ethno-specific organizations should develop integrated linkages at the administrative and service delivery levels in order to ensure that minority groups have adequate access to services offered by mainstream organizations. The lack of networking among community agencies had also been reported by Flaskerud (1986). Thus, the importance of outreach efforts in service provision should be emphasized by mainstream mental health and social service organization in order to facilitate accessibility.

As stated earlier, the issue of underutilization of community mental health services by immigrants and refugees was acknowledged by the Canadian Task Force (1988b). With respect to underutilization of services, Skartvedt, Rick, and Coen (1987) found that making referrals to mental health services for this population is difficult as immigrants and refugees are reluctant to be referred and the needed service is often not available in the service system. Quan (1987) found that utilization of services is hampered by the presence of linguistic and cultural barriers which affect the adequacy and appropriateness of services being provided to the refugee client.

Mental health and social service providers have also been viewed as not being culturally sensitive to immigrants during the provision of services. It has been noted that few mental health and social services offer any systematic opportunities to sensitize staff to cultural issues (Canadian Task Force, 1988a; Doyle & Visano, 1987). In Doyle and Visano's study, the most frequently cited strategy to reduce cultural

barriers by mental health providers was the provision of training to staff, but only 45% of service providers actually offered this type of training.

Some immigrants can also have cultural beliefs which foster negative perceptions of mental health, and may not see mental health and general health as distinguishable (Van Arsdale, 1988). These perceptions of mental health can encourage immigrants to view mental health services as not acceptable or culturally appropriate. In addition, religious beliefs have been reported to influence health beliefs, the immigrant's reactions to illness, and subsequent use of the medical system (Hoang & Erickson, 1985). For example, in Buddhism suffering is perceived to be an integral part of one's life and divine punishment for unrighteous behaviour. Thus, seeking medical help for physical pain may be avoided and/or delayed by those in need. This may lead to underutilization.

Other cultural beliefs that can influence an individual's attitude toward mental health services include the attribution of physical etiology to mental illness or perceiving help-seeking as a personal weakness and as a disgrace to one's family (Crystal, 1989). Crystal also noted that some immigrants' cultural attitudes can create further barriers through their preference for obtaining services from an indigenous healer or through reliance on intrafamilial resources.

In addition, the gender and age of the mental health staff providing service, the lack of understanding of Western medicine (Humm-Delgado & Delgado, 1986), and the tendency of clients to doubt the benefits of treatment they do not understand (Canadian Task Force,

1988a) can be additional barriers. Humm-Delgado and Delgado (1986) found the social norms of Hispanics interfered with interviewers who were not the same sex as the client as these circumstances gave the appearance of impropriety. The issue of age differences between interviewer and client was described as a factor hindering trust and communication. Some Asian cultures are known to place a great importance on silence and nonverbal communication which hinder attempts at service implementation (Crystal, 1989). The stigma attached to a mental disorder (Canadian Task Force, 1988a), as well as the fear of being looked down upon (Stefl & Prosperi, 1985), have also been noted in the research.

Other pertinent cultural barriers have included the fear of deportation (Canadian Task Force, 1988) and the immigrant communities' distrust of agency personnel who ask questions that are perceived as government monitoring (Humm-Delgado & Delgado, 1986). The issue of racial discrimination on the part of the service provider (Orr, Miller, & James, 1984), the middle class orientation of mental health staff, as well as culture bound diagnosis effects on immigrants remaining in treatment (Fischman, Fraticelli, Newman, & Sampson, 1983) have also been reported.

The matter of cultural sensitivity and the provision of specific training programs to staff on cultural awareness is yet another aspect of planning for the board and administration of an organization to consider. Consulting with ethno-specific organizations on various aspects of the training program would likely facilitate its usefulness to the direct care staff as well as enhance working relationships with

these organizations.

The importance of linkages with ethnocultural groups, clergy, traditional folk healers, and immigration services have been well documented, as these services tend to be the community resources that an immigrant or refugee approaches first when in need of support (Coen, 1987; Doyle & Visano, 1987; Humm-Delgado & Delgado, 1986). The lack of interagency collaboration with these sources in the community has been well documented by these researchers (Doyle & Visano, 1987).

An additional barrier that can also be addressed at the planning level is an organization's hiring practice (e.g. lack of Affirmative Action procedures) within the workplace (Guerriro-Klinowski & Turkewych, 1986). However, this barrier is not easily remedied by a service organization as certification procedures of professional regulatory organizations often do not recognize foreign credentials of immigrants seeking employment in social service agencies (Crystal, 1989; Doyle & Visano, 1987). A general impression from researchers is that mental health service providers that employ qualified staff from a variety of cultural backgrounds may be better able to provide services which are more culturally appropriate (Coen, 1987; Doyle & Visano, 1987).

The lack of multicultural representation on an organization's board has also been seen as a barrier to immigrants having access to an agency's services (Doyle & Visano, 1987). The role of board members encompasses issues related to planning, community outreach, service design and implementation as well as evaluation of an organization's services. This is yet another issue for an organization to address at

the planning level.

Related to this issue is the extent to which an agency has designed explicit policies that deal with adequate board representation, hiring practices of staff, cultural training of board and staff members, community outreach, volunteer recruitment, and interagency linkages (Doyle & Visano, 1987). Doyle and Visano suggested that the reduction of obstacles to facilitate service delivery to the immigrant population must be seen as a priority of the mental health provider. Their conclusion was that this is not seen as an urgent issue by the mainstream mental health providers who were surveyed. Few organizations in their study had actually made any changes beyond identifying barriers.

Researchers have also identified additional barriers that an agency can address at the organizational planning level. The Canadian Task Force (1988a) noted that organizations need an efficient data retrieval system in order to increase their awareness of developments and changes in service delivery. Orr, Miller, and James (1984) highlighted other barriers as being the proximity of the organization to the immigrant and refugee populations needing assistance, the restrictiveness of the hours of operation (e.g. not offering evening, weekend, or 24-hour services) and the type of telephone reception offered (e.g. person versus answering machine).

At the service program implementation level, several barriers have been identified by researchers which affect all individuals seeking mental health and social services. Stefl and Prosperi (1985) reported that the dominant service barrier to mental health service utilization

related to the affordability dimension (e.g. cost of services). Other researchers have also supported the belief that charging a fee for services rendered was a barrier to service access (Canadian Task Force, 1988a; The Women and Mental Health Project, 1976). Additional costs that can be incurred by the client can include daycare and transportation (Doyle, 1986), the lack of employment-related health insurance benefits (Boehnlein, 1987), and the need to take time off work in order to receive the services (Stefl & Prosperi, 1985). In Canada, the lack of employment-related benefits is more of an issue for obtaining non-medical services.

Specific to immigrants and refugees, several researchers have highlighted language as a major barrier to accessing services (Canadian Task Force, 1988a; Hoang & Erickson, 1985; Uba, 1982). The issue of language barriers in service implementation can take on importance from several perspectives. Uba (1982) noted that Asian Americans' reactions to language issues discouraged them from seeking services and also hindered their knowledge about available services in the community, their interactions with service personnel, and the completion of agency intake forms.

The importance of having access to appropriate interpreters when providing direct care service has been reported in numerous research reports (Canadian Task Force, 1988a; Doyle & Visano, 1987; Van Arsdale, 1988). The necessity for this type of linguistic support in psychiatric assessment and treatment cases has been emphasized by Westermeyer (1990). Another investigation noted that the rate of misdiagnosis was alarmingly high when cross-cultural diagnostic methods were not used

(Boxer and Garvey, 1985). Boxer and Garvey assessed the reproducibility of the psychiatric diagnoses made in immigration proceedings of 109 refugees who had appealed their diagnoses. In this study the medical review boards sustained the original diagnoses in 62 out of 109 cases (57%). With respect to the specific diagnosis of antisocial personality, only 23 out of 55 cases (42%) were upheld. In the remaining 54 cases, 39 (72%) of the diagnoses were affirmed. In some cases only a minor change in a diagnosis was highly significant for accepting or rejecting a refugee claimant. Other researchers have noted the actual presence of fragmented services being provided to clients as another type of barrier (Canadian Task Force, 1988a; Hoang & Erickson, 1985). Difficulties arise because immigrant and refugee needs do not easily conform to the specialties of some agencies. In addition, services offered by different organizations may be uncoordinated, or offered by large organizations that can be confusing to immigrants and refugees.

The advantages and disadvantages of utilizing interpreters have also been analyzed. Van Arsdale (1988) argued that to provide cross-culturally appropriate services, organizations did not necessarily have to hire their own bicultural/bilingual staff, but that they must ensure the provision of access to interpreter services in the system. However, other researchers have emphasized the lack of bilingual or multilingual staff at mental health agencies as a barrier to service provision (Cravens & Bornemann, 1987; Uba, 1982).

With respect to the use of interpreters, the Canadian Task Force (1988b) reported that interpreters can be perceived as being

authoritarian and as distorting the information that is being translated. Furthermore, there is concern that interpreters do not have the training nor adequate abilities to interpret and translate information between the mental health professional and the immigrant client.

Mental health and social service providers must be informed of the issues related to using interpreters to assist them in the provision of services to immigrants and refugees. Westermeyer (1990) described key elements that are useful in selecting, training, and assigning an interpreter for psychiatric and social service interventions. Interpreters require both didactic and on-the-job training which emphasizes the development of skills in translation and interpretation. Interpreters also should be able to adequately understand the professional terminology utilized in assessment and treatment, to respect issues of confidentiality in the therapist-client relationship, and to comfortably relate to others in the mental health and social service setting.

The aspect of language as a barrier to providing an agency's services is a multifaceted issue. Mental health and social service providers must acknowledge the effects which language has on providing adequate services to clients. Moreover, service providers must ensure that plans are in place at the management level that reduce the barrier of language as it pertains to service accessibility and utilization. Otherwise, as Doyle and Visano (1987) note, many prospective consumers will not be attracted to an agency where information can only be exchanged through the English language. One important administrative

planning activity would be for management and direct care staff to demonstrate an increased effort to network (e.g. case specific, facilitating language interpreters and training) with ethnocultural groups and immigrant serving organizations.

At the implementation level, additional barriers faced by immigrants and refugees have been identified and include the following: difficulty conveying sensations of mental disorder to mental health staff (Canadian Task Force, 1988a), lack of understanding of the professional's role (Crystal, 1989), the way in which the service is delivered (e.g. brief/active therapy versus a passive, therapeutic approach), and the appropriateness of the kind of service (e.g. individual versus family therapy) being delivered (Doyle & Visano, 1987). Hoang and Erickson (1985) noted the issue of family structure (e.g. patriarchal) can also be a factor when attempting to provide mental health services to the immigrant population. In Vietnam, Cambodia, and Laos, for example, the family is patriarchal. These families may be large and extended, and decisions to seek medical and/or mental health care are made by the eldest member of the family. However, the method, type, and appropriateness of the service being delivered cannot be generalized across all immigrant groups.

The importance of evaluation in the provision of mental health and social services has been noted by researchers (Patton, 1978; Rossi & Freeman, 1989). Rossi and Freeman suggested that service providers are continuously faced with devising ways to remedy serious deficiencies in the quality of human life and thus must develop and create new initiatives and improve existing services. Evaluation of service

endeavors can heighten management's awareness and control of the issues affecting accessibility to services. Patton (1978) noted that evaluation is comprehensive and that service utilization is affected by all components of the evaluation process (e.g. initial conceptualization, data analysis, interpretation).

The evaluation of the services provided by an organization is an important function over which the board and management levels have ultimate control. When reviewing the literature specific to evaluation of services regarding their accessibility for immigrants and refugees, researchers generally restrict this function to the identification and suggested removal of barriers. Unfortunately any further elaboration as to the importance of evaluation of an agency's services related to accessibility is essentially nonexistent.

The lack of funding being provided to organizations to improve effectiveness of service implementation was reported by the Canadian Task Force (1988a). The Task Force recommended that Health and Welfare Canada and the Secretary of State encourage all funders of social and health services to require organizations requesting funds to describe efforts made to make their services more accessible to ethnic populations, as well as provide evaluations related to their effectiveness. It was felt that this requirement would make service agencies more responsive to the needs of immigrants and refugees.

Surveys of Mainstream Service Providers

Several researchers have conducted investigations that were directly pertinent to the present examination on accessibility to mainstream mental health and social services by immigrants and refugees.

However, none of these studies utilized a telephone survey of managers geared to examining access issues from the perspective of administrative functions within the organization, as well as consulting and networking practices with other organizations in the community.

Doyle and Visano (1987) conducted an examination of access to health and social services organizations by diverse ethnocultural groups located in Metropolitan Toronto, Ontario. The methodology included face-to-face interviews with 135 health and service organizations, as well as self-administered questionnaires which addressed organizational data with regard to access to service. The respondents were direct service supervisors who represented a wide range of organizations (e.g. advocacy organizations, educational institutions, major ethnocultural groups, and government and voluntary sector agencies).

In the Doyle and Visano study, a comparative perspective was used for barrier and strategy identification, and for examining viewpoints on the roles and functions of mainstream and ethnocultural service providers. A total of 40 key informants from affected communities were selected through the reputational method (i.e. persons known as opinion influencers and/or leaders in the multicultural community). Face-to-face interviews were subsequently conducted with these individuals. Qualitative information was obtained on barriers from consumers of services. Funding policy reviews, case studies of innovative services, and focus groups were also utilized. The focus groups were held in six municipalities involving a diverse range of interested persons. In the study, seven of the organizations refused to participate as a result of being short-staffed, however 44% (60 respondents) of the self-

administered questionnaires were completed. Less than 25% of the providers interviewed completed all sections of the self-administered questionnaire.

Doyle and Visano found that service providers and key informants agreed that the general public was not well informed about services offered by the mainstream organizations. Furthermore, 81% of the service providers offered information to the public in only the English language. These researchers suggested that service providers would have difficulty arguing that they had made a serious commitment to increasing access of services to diverse cultural and racial populations. For example, mainstream organizations were generally able to identify barriers to access but strategies to overcome these barriers were limited. As noted earlier, the most frequently cited strategy to reduce cultural barriers was providing cultural training to staff. However, only 45% of the respondents indicated that they furnished this type of training.

Doyle and Visano also suggested that the issue of ethnocultural board representation and its effect on client access was not seen as a priority for service providers as only 4% of respondents noted attempts to increase the representation of various cultural groups. Moreover, only 30% of key informants (primarily from ethnocultural communities) and 11% of service providers suggested a need for greater board representation as a system-wide solution for improving client access to services.

The majority of mainstream health and social service providers (75% of the respondents) were also found not to have clearly established

policies related to staffing strategies to enhance access to services by ethnocultural groups. Examples of specific strategies included hiring practices and staff training/development. Information obtained from the key informants suggested that ethno-specific organizations were responsive to the needs of consumers despite limited resources and personnel as they often placed an emphasis on improving access to services through policy making decisions.

Consumer-reported barriers included the lack of information, personnel, communication strategies, the unavailability of service, and the lack of understanding of linguistic and cultural factors in service provision. Remedial strategies suggested for mainstream organizations included providing supportive services, information and referral services, and the use of multicultural staff. Doyle and Visano (1987) stated that the problem of access "does not lie with direct service workers but in the general failure of the management of organizations to recognize the unique need for service for members of diverse cultural and racial groups" (p. 135). The importance of management facilitating access to services is crucial, but of equal value is the access created for clients through the desire and willingness of the direct care staff to network with other ethnic organizations in a collaborative manner.

When evaluating the study conducted by Doyle and Visano (1987), particular issues are worthy of discussion in relation to the reported conclusions. First, there is uncertainty as to whether the selected sample was representative of the mainstream service providers in the Metropolitan Toronto area. The selection process was described as a systematic sample based on the size and type of organization, type of

program service offered, and the geographical area. The use of a statistical methodology to facilitate a representative sample of respondents was not specified. Second, the primary focus of the project was on examining the perspectives of the mainstream service provider in regards to access. However, only 44% of the providers returned the self-administered questionnaire. Thus, 56% of the providers did not furnish information on a variety of issues related to access for members of diverse cultural and ethnic groups. The languages offered at reception, types of services provided and proposed to increase access to ethnocultural groups, information about multicultural representation at the board, management, direct care, and volunteer levels, as well as details on policy, planning and funding were not given by the majority of the providers.

The ability to generalize the findings of the Doyle and Visano study to the current study is lessened by the fact that the present investigation is more focused and addresses access issues for immigrants and refugees and not of the larger population of diverse cultural and ethnic groups. In addition, the methodologies used in the two studies were not the same. However, where possible similar questions were asked in the present study to provide some comparability with the investigation conducted by Doyle and Visano. (The similarity in the questions is elaborated upon in Chapter III.)

In another study, Coen (1987) utilized a mail survey of mental health service providers in the state of Colorado to develop profiles of individuals who provide services to refugees, obtain information on the training backgrounds and needs of service providers, identify social and

mental health problems in the general refugee population, as well as collect recommendations from service providers for improving service delivery to this population.

The survey was distributed to 122 individuals at the upper and middle management, direct service, consultant, and volunteer levels. A return rate of 65% (79 respondents) was obtained with representation from 30 organizations including mainstream agencies, institutions and private businesses. The respondents included both refugee service providers (29%) and non-refugee service providers (71%). In this study a refugee service provider was defined as someone who had been a refugee prior to entering the United States, whereas a non-refugee service provider was a person born in the United States or someone who had immigrated with other than refugee status.

In general, Coen found recruitment of staff at agencies to be ethnically and demographically diverse. With regard to ethnicity, half of the individual service providers were non-white with almost two-thirds of these respondents having originated from Southeast Asian countries. In addition, non-refugee service providers were well distributed with respect to responsibility and authority in the mental health setting, whereas refugee providers were essentially concentrated in direct service positions. Training needs were expressed by only 10 of the 79 mental health service providers. Requested skill development areas included refugee resistance to services, problem identification, and service delivery within a cultural context. Other recommendations included improving the skills of bilingual mental health staff and developing community programs in mental health education and outreach

services.

Coen provided an overview of concerns related to the mental health needs of refugees from the perspective of a wide range of service providers, and staff at various levels within these organizations. The results are described with no intent to consider differences in viewpoints between the public and private sector service providers, or between managerial, direct care, and volunteer personnel. The findings cannot be totally generalized to the present study conducted in Winnipeg as the Coen investigation was concerned with a narrower population (i.e. refugees) and service provision in rural as well as urban areas. However, attempts were made to utilize some similar questions from the Coen study in the present investigation to provide some comparability.

Quan (1987) examined the mental health needs and utilization of psychiatric hospitals and community mental health centres by refugees in Texas. A mail survey was sent to 444 key informants who were considered service providers and/or refugee community leaders knowledgable about the problems of refugees, their help-seeking behaviours, and factors that make the mental health delivery system more responsive to refugees. Examples of respondents included persons from voluntary resettlement agencies, private physicians, school districts, universities, police departments, county/city health departments and hospitals, religious organizations, community mental health centers, and state hospitals. The study had an overall response rate of 75% (352 responses) of which 16% were eliminated from the study due to their reported lack of contact with, or knowledge of, the needs of refugees.

Additional information was obtained from a state hospital

utilization survey and a survey of two of the 34 community mental health centers in Texas (in Houston and Dallas) which were found to be located near the residences of larger populations of refugees. The focus of these two surveys was on refugees that had actually been admitted to the mental health system.

The objectives identified in Quan's study centred on understanding the problems of refugees, their help-seeking patterns, the barriers to obtaining services from the mental health system, and the identification of factors which would enhance accessibility and effectiveness of these services. Overall, the results of the three surveys indicated that linguistic and cultural barriers were major obstacles that hindered adequate and appropriate service delivery to this population. Furthermore, rigid administrative constraints were seen as preventing direct care staff from accessing resources available within the mental health care system as well as the community. An example identified as an administrative constraint was the assignment of refugee clients to psychiatric and medical staff of the same ethnic background on the basis of chance. Quan concluded that the mental health system examined in the study was not responsive to the needs of refugees. Quan's findings appear to be justified as linguistic and cultural considerations were not given significance in the provision of mental health services to the refugee population. The issue of the mental health system being unresponsive to everyone regardless of ethnicity and legal status was postulated without any supportive research being provided.

The research reviewed during the preparation of this study is limited with regard to not considering the attitudes of mental health

and social service providers toward the immigrant and refugee populations. Doyle and Visano (1987) examined the perceptions of service providers in relation to barriers to health and social services by diverse cultural and racial groups. These researchers findings were previously discussed and are geared to a broader range of client services than is the present study.

In a broader study that is somewhat removed from the current study, Berry, Kalin, and Taylor (1977) examined multiculturalism and ethnic attitudes in Canada according to four attitude domains. The domains addressed were Canadians' attitudes toward ethnic groups, multiculturalism, immigration, and ethnic prejudice and discrimination. A total of 1849 respondents were administered face-to-face interviews. The sample of respondents were selected from a national sampling frame, covering approximately 95% of the population of Canada. The only excluded individuals were persons living in institutions, on reservations, and in the extreme northern parts of Canada. The respondents were at least 16 years of age and able to speak English or French. The completion rate of the interviews was reported as being 70%. The validity of the attitude measures was reported as reasonable but no specific data were provided. Essentially this study examined the attitudes of the general population of Canada toward multiculturalism.

Their results indicated that there was evidence of race being employed by respondents as an important dimension in their perception of ethnic groups, although overt bigotry and racism were not demonstrated. Finally, respondents with higher socioeconomic status, as well as those who possessed higher levels of education, held more positive attitudes

across the aforementioned attitude domains. These attitude findings are generalizable to the present study as the management staff interviewed would generally be from an adequate socioeconomic background and possess at least some post secondary education.

In conclusion, the survey research that has been reviewed in this chapter indicates that there is a lack of administrative preparedness by service providers to meet the needs of immigrants and refugees. Many of the barriers that were reported in other literature were substantiated as a critical concern in the surveys' findings. Administrative personnel in a variety of service agencies do not appear to be adequately addressing the barriers that occur at the planning, service program implementation, and evaluation levels. Examples include the linguistic and cultural barriers that are present at each of these agency function levels. The lack of organizational planning and evaluation activities related to board membership, cultural training of staff, access to qualified interpreters, and community networking practices are specific examples of inadequate administrative procedures with regard to accessibility.

Although research has been conducted that is pertinent to the present examination on accessibility to mainstream mental health and social services by immigrants and refugees, no studies have utilized a telephone survey aimed at examining issues of access from the perspective of administrative functions within the organization. Access issues related to attitudes and beliefs of the service provider to the immigrant and refugee population have not been researched to any great extent. Investigators have reported that linguistic and cultural

barriers, inadequate networking between mainstream and ethno-specific organizations, the lack of multicultural representation on boards, the provision of cultural training to staff, and the development of culturally relevant policies are issues that effect access to services by various ethnic and racial populations.

The present investigation examines each of these issues from the management perspective. It is hoped that the present research findings will provide information on accessibility that is useful to mental health and social service providers, ethno-specific organizations, and consumers of mental health services. The results may provide an impetus for administrators of mental health and social services to examine organizational policies, methods of planning, service delivery, and networking patterns with ethno-specific organizations. Ethno-specific organizations may view the present research findings as a means to enhance their advocacy role for immigrants and refugees by facilitating dialogue on access with mainstream providers of mental health and social services.

III. METHODOLOGY

General Aims and Design

As was noted in Chapter II, researchers have identified barriers which immigrants and refugees experience when attempting to access mental health and social services. However, to date the presence of these barriers and the means to control and lessen these obstacles within the mental health and social service organization have not been fully examined.

The present study was conducted as there was a lack of knowledge about the extent to which barriers to an agency's services are affected by the organizational functions of planning, service program implementation, and evaluation. In addition, little was known about the attitudes and beliefs of administrative personnel within the organization. The rationale for examining the attitudes of these individuals is that they have a significant influence over how the agency provides services.

A cross-sectional survey design was utilized to obtain descriptive information from mainstream mental health and social service providers on barriers to service provision. The strength of this type of design is that it provides descriptive information that can be used for formative purposes and for facilitating the development of policies and procedures in the area of concern (Tripodi, 1983). Information collected from management respondents related to planning activities

that address accessibility to services, service delivery practices, managerial attitudes and beliefs, client tracking processes, and service utilization. It was used for description and comparison of responses provided by managers employed in the public and private (i.e. voluntary) sectors, and institutional and community service organizations.

Despite the present study's limitation of not being able to determine causal ordering between various variables, six correlational hypotheses were tested as follows:

1. Specific planning activities related to access will be positively associated with greater service utilization.
2. Favourable managerial attitudes toward immigrants and refugees will be associated with attempts to decrease barriers to access at the service delivery level.
3. Immigrant and/or refugee board membership will be positively associated with attempts at the planning level to lessen the barriers to service.
4. Service providers that have a means of identifying and tracking immigrant and refugee clients will have more procedures in place to increase cultural accessibility than those providers that do not identify immigrant and refugee status.
5. Service providers that have bilingual staff and/or which utilize interpretive services will have a greater proportion of immigrants and refugees among their clients than those which offer services in only the English language.
6. Service providers that hold beliefs that immigrants and refugees have unique problems which can make it more difficult to access

services will have made more attempts to decrease barriers at the service implementation level.

Respondents and Sample Selection

The study was designed as a census of all mainstream mental health and social service providers in Winnipeg which met specific criteria for inclusion in the investigation. The Community Resource Guide for Manitoba (Contact Community Information, 1991) was the sampling frame utilized in compiling the list of providers.

As noted in Chapter II, "mental health and social services" were defined as those mainstream institutions and community based programs that provide assessment, counselling, and/or treatment services to meet mental health and/or social service needs. To be considered as a service provider in the present study, Doyle and Visano's (1986) definitions of mainstream and ethno-specific organizations were employed. Only mental health related services that were viewed as mainstream organizations were examined.

An additional criterion utilized in determining eligibility for inclusion in the study was the presence of paid staff. Thus, organizations which consisted of only volunteers were not included. Professionals in private practice were also excluded from the study as these service providers were viewed as having different governing structures, planning, and service delivery functions than those of public and voluntary sector mainstream mental health and social service organizations.

A letter was sent to the administrator of each agency to identify and survey the management staff who was perceived by this individual as

the most knowledgeable about agency services to immigrants and refugees (see Appendix A). The staff member to be surveyed was either the administrator or the agency manager identified by the administrator as knowing the most about services to immigrants and refugees.

There were some large organizations which offered numerous and distinctive mental health and social services within one setting. In order to survey these more complex organizations, the administrator was asked to designate a management level staff from each distinct area that provided mental health related services. As a result, 23 staff were interviewed in these eight larger organizations. The data obtained from the respondents at these larger organizations varied considerably and a decision was made to consider these respondents separately.

In order to determine which mental health and social services would be considered eligible for this study, the present author and another individual in the mental health field independently assessed 112 agencies and community programs to see which met the previously stated criteria. The same criteria were used by each rater to examine the potential services, and to develop a final list of services to be contacted. An interrater reliability assessment was conducted which found a 94% agreement between the two raters ($Z=9.36$, $N=112$, $p<.01$).

The initial sample consisted of 76 agencies which met the respondent requirements. Seven agencies were added to the sample which included the agencies where there had been disagreement between the two raters to ensure that the census would include all appropriate agencies. There were an additional six organizations for which the two raters agreed there was not enough information provided in the Community

Resource Guide for Manitoba to establish respondent criteria selection. All six of these organizations were included as this ensured that all organizations which might meet the respondent criteria would be contacted. Thus, a total sample of 89 agencies was identified for screening for inclusion in the census.

Of the 89 mainstream organizations that were contacted by the author, only nine agencies refused to participate. This equalled 10% of the total sampled. The reasons given by these individuals for not participating in the census were a stated lack of interest (N=1), not being able to find suitable staff to be interviewed (e.g. on vacation) (N=1), objection to the use of telephone interviews (N=1), and a statement by two individuals of not providing services to immigrants and refugees (N=2). Several phone messages were left by the author at three organizations and there were no return calls. One interview was terminated near the beginning of the questionnaire as the respondent indicated that the questions were based on too many assumptions. Only two of the nine refusals were able to be verified as having met the inclusion criteria. The nine organizations that refused to be surveyed were categorized into the following typologies: one publicly funded versus eight privately funded, and four community based versus five institutionalized services.

A total of 10 agencies that were contacted did not meet the previously stated criteria. This represented 11% of the total sample of 89 organizations. Therefore, the respondents who completed the telephone interview represented 70 organizations. This is an overall response rate of 89% assuming that the 9 refusing organizations met the

respondent criteria for inclusion into the present investigation. However, a total of 85 respondents participated in the present study. Of the 70 organizations from which managers were interviewed, eight agencies had more than one respondent completing the questionnaire with the total number of respondents for these eight agencies being equal to 23.

The expected time to administer the telephone questionnaire was 20 to 30 minutes. The measures of central tendency were computed for the time required for conducting each questionnaire and were as follows: mean=30.14 minutes, median=30 minutes, mode=30 minutes. The range of time for administering the survey was 18 to 50 minutes with the variance being 50.41 and a standard deviation of 7.10 minutes. A total of 44 respondents (52%) completed the questionnaire in the 20 to 30 minute timeframe. Another 39 service providers (46%) required more than 30 minutes, and 2 respondents (2%) needed less than 20 minutes to complete the survey.

Data Collection

As noted in Chapter II, surveys have been successfully used by other researchers to assess barriers to service utilization by immigrants and refugees (Doyle, 1986; Quan, 1987). The decision to utilize a telephone survey to examine issues of access to mainstream mental health and social service agencies by immigrants and refugees was determined as part of the thesis proposal.

Dillman (1978) reported that individuals who have used his survey methodology have had an average response rate of 91%. This response rate was seen as optimal as 28 studies that have used his methodology

have produced average response rates of 77%. It should be noted that the response rate is dependent on the sample being surveyed. For example, Hurh and Kim (1990) used telephone survey methods specific to mental health issues with immigrants and obtained a response rate of 62%. Rossi, Wright, and Anderson (1983) also noted average response rates as being dissimilar for different populations sampled.

In the present study, the overall response rate for those organizations that met the respondent criteria was 89%. This relatively high response rate was facilitated by the use of Dillman's survey methodology, and additionally, by offering respondents several times during the day and/or week to be interviewed, the researcher's utilization of an answering machine and a secretary to handle incoming phone calls, and administering the survey in late summer when the demands upon managerial staff are generally more relaxed.

Several strengths of using telephone surveys have been noted by researchers and include: the ability of investigators to reach a majority of the target population, the low costs associated with data gathering, the ease of administration, and the generation of reasonably reliable results through the ability to interact with respondents (League of California Cities, 1977). Dillman (1978) also reported that telephone surveys offer researchers a high degree of assurance of a representative sample given high response rates. It should be noted that the guarantee of a representative sample is dependent on the sampling procedures utilized.

Dillman (1978) also noted that telephone surveys offer a high degree of success when using either open or close-ended questions,

provide control over the contamination of responses by individuals other than the respondent, and have high degrees of success in obtaining responses to questionnaire items. Li (1981) indicated that telephone surveys have a high completion rate and can reach respondents quickly, making them well-suited for opinion surveys of current issues.

Telephone surveys do have limitations. A drawback of telephone surveys is their tendency to create community expectations that the survey results will be used by decision makers. However, since the survey used in this study was likely viewed by respondents as an academic investigation with no direct effect on decision makers, the drawback of heightened expectations was minimized. Dillman (1978) and Jackson (1988) noted that telephone surveys are not effective with questions that are complex in nature. Li (1981) indicated that researchers are under pressure to limit the time period of the telephone interview as longer interviews have been reported to create fatigue in the respondents. These time constraints can put restrictions on the amount of information collected. Also, visual aids are generally not used in telephone questionnaires which can create comprehension difficulties for some respondents.

The process of administering the telephone survey followed the guidelines of several researchers (Dillman, 1978; Fowler, 1988; Frey, 1989), with the primary resource being Dillman. Methods that were proposed by Dillman (1978) that were part of the present study included: sending an advance letter to each service provider prior to the telephone interview (see Appendix A); using a centralized interviewing facility (i.e. Child and Family Research Group, Faculty of Social Work,

University of Manitoba); pre-testing the telephone questionnaire; having procedures in place that addressed respondent confidentiality and concerns regarding surveys in general; scheduling of interviews; and offering a copy of results of the study to respondents when completed.

The telephone surveys were conducted by the author in August and September, 1991, during normal business hours over a four-week time period. Approximately one week after the mailing of the advance letter, the author contacted each agency administrator by telephone to assess his/her willingness to participate in the survey, and to identify specific managerial respondents. In order to obtain the most appropriate respondent to be surveyed, the administrator of each organization was asked to name one or more persons at the managerial level whom they felt was the most knowledgeable about their agency's services to immigrants and refugees. In some cases the administrator of the organization was the selected respondent. A summary report of the survey results was promised to respondents requesting copies.

In order to ensure confidentiality for each telephone respondent, the answers given during the interview were transferred from the telephone questionnaire to another form with no name being recorded. The completed questionnaire was then destroyed and all information released in subsequent reports will ensure that no specific responses were attributable to individual respondents. The respondents' close-ended responses and some qualitative responses were coded and tabulated for subsequent analysis.

Instrumentation

The thesis committee provided guidance during the construction of

the thesis proposal which included the discussion of relevant literature, the determination of the research design, and the development of the framework for the telephone survey instrument. The questions utilized on the survey instrument were designed to allow for the analysis of accessibility issues according to four domains (i.e. organizational functions of planning, service program implementation, evaluation, attitudes and beliefs). The thesis committee also facilitated the recruitment of members for the external advisory group which assisted in the development of the telephone questionnaire and analysis of the survey findings.

The use of an advisory group has been reported as useful in other research related to immigrants, particularly in relation to obtaining access to the immigrant community, providing insights into the data obtained, and in adding support and credibility to the study (Humm-Delgado & Delgado, 1986). The advisory group utilized in the present study had a range of expertise as well as diverse perceptions regarding the mainstream mental health and social service system in Winnipeg. The composition of the advisory group included representatives from a mainstream mental health service, an immigrant serving agency, an ethnocultural group, and provincial mental health services. The initial plan was to have an immigrant or refugee who had been a consumer of a mainstream mental health and social service as part of the advisory group. Several attempts were made to meet with potential participants by the representative from the immigrant serving agency, but were unsuccessful despite the assurance of anonymity. Consequently the advisory group did not include an immigrant or refugee who had been a

consumer.

Contacts with members of the advisory group included the initial presentation of the research project, a letter detailing the role of the advisory group (see Appendix B), the discussion and determination of the most crucial barriers affecting accessibility of services by immigrants and refugees, the specification of items and responses on the questionnaire, the pretesting of the telephone questionnaire, and the discussion of the findings from the survey. The utilization of the advisory group was beneficial in determining which of the issues identified in the literature related to accessibility were addressed in the survey. In addition, the wide range of expertise and perspectives of the members of the advisory group added credibility to the study. However, attempts to secure an immigrant or refugee consumer to be a part of the advisory group were not able to be facilitated by the group's members.

The strategies used to design the telephone questionnaire were proposed by Dillman (1978). Dillman's methods are concerned with identifying and designing each aspect of the survey process that can affect response rates, and with organizing the survey effort to assure that the design intentions are carried out in complete detail.

The construction of the survey instrument took into consideration the needs of the respondent, interviewer, and coder. For example, the questions and response categories were pretested for length and complexity in order to minimize difficulties for the respondent and interviewer. The information on the survey form was designed so that the responses could be easily coded to maximize efficiency in survey

administration and subsequent computer analysis.

The telephone survey instrument (see Appendix C) had a cover page that included demographic information on the respondent and his/her designate, an introductory statement from the interviewer, and codes for contacts with respondents, requests for a summary report, final status of the survey, and the timeframe needed for survey administration. The second page of the questionnaire confirmed the receipt of the initial letter to the respondent (see Appendix A), secured the voluntary participation of the individual, and utilized screening questions to ensure that each respondent met specific criteria for inclusion into the study.

The telephone survey instrument was 13 pages in length with 68 questions including both open and close-ended formats. The decision to use both types of question formats emphasized a quantitative-qualitative approach to examining managerial responses, and was consistent with Dillman's design methodology.

Open-ended questions were used to elicit opinions from survey participants regarding accessibility issues. These types of questions aided in understanding the framework of the respondent. Patton (1987) indicated that the qualitative-naturalistic approach is especially appropriate for facilitating more effective program implementation, as well as when exploring effects on participants. For example, question 2 asks the respondent to list the barriers they believe are the most impeding to providing services to immigrants and refugees. Question 3 requires respondents to define the terms immigrant and refugee.

Close-ended questions were used when it was felt there was enough

understanding of the response categories, or when the possible range of responses were based upon empirical evidence from the literature. One close-ended question is number 6 which asks a service provider to compare his/her agency's services to that of other mainstream organizations with respect to cultural accessibility. Another example is question 17, drawn from Quan's (1987) investigation of refugees, which inquires whether the respondent's organization has ready access to qualified interpreters to assist in its work with immigrants and refugees. In both of these questions, respondents were asked to choose a response presented in a rating scale format.

Dillman's procedures for the ordering of questions were also used in the design of the telephone survey. The questionnaire began with items central to the topic of accessibility which were written with an emphasis on creating interest and a sense of social importance. All topical questions were asked before items related to the personal characteristics of the respondent and organization. Items that could be perceived as objectionable were placed near the end of the survey, but preceding questions on personal characteristics. Questionnaire items which focused on beliefs about immigrants and the adequacy of the mental health and social service system (e.g. number 24) are examples of possibly invasive questions.

Additional strategies in the questionnaire design included the logical and orderly presentation of topics and questions. Response categories were kept the same for questions that occurred in a sequence, and answer categories were precoded to facilitate computer analysis. Screening questions utilized arrows to connect the selected response

categories in order to facilitate the recording process and to reduce the chance of coding errors. An example of the screening process is question 17: "Do you have ready access to qualified interpreters to assist you in your work with immigrants and refugees?". The page break for questions was designed to make the interview process more efficient.

Attempts were made to use similar questions from survey instruments used in past research (Doyle & Visano, 1987; Quan, 1987). It should be noted that these researchers utilized different methods for collecting data (i.e. face to face and/or mail surveys). Despite the methodological differences from the current study, the present telephone questionnaire had items that were similar to those in the Quan investigation. For example, item number 17 asked the respondent if his/her organization had ready access to qualified interpreters to assist in working with immigrants and refugees. Quan, however, analyzed responses according to the ethnicity of the respondent. For example, her results revealed that 54% of Ethiopian respondents had access to qualified interpreters most of the time. These results are not readily comparable to those of the present investigation. However, an analysis of the responses to this question in the present study and a comparison to the Quan study are presented in Chapter V.

Item 11, which addresses an agency's policies to improve access, was similar to a question used in the Doyle and Visano (1987) investigation. However, the question on policies in the Doyle and Visano mail survey used more specific response categories and was addressed to organizations that provided services to a wider range of clients that included individuals from diverse cultural, linguistic, and

racial groups. Despite these differences, Doyle and Visano found that the majority of service providers did not have clearly established policies related to hiring practices (75%) or staff training (70%). A comparison of the present study's findings with regard to established policies is provided in Chapter V.

The rationale for pretesting survey instruments has been noted by several researchers (Babbie, 1973; Dillman, 1978; Kidder & Judd, 1986; Rossi, Wright, & Anderson, 1983). Rossi, Wright, and Anderson (1983) suggested that pretesting be conducted with individuals who are similar to the population to be sampled. Pretesting facilitates: improvements to the open and closed-ended questions; adjustments to the time required to complete the questionnaire; clarification of items which might be irrelevant to the study; and improves the flow of information between the interviewer and respondent.

The telephone survey instrument was pretested over the telephone during July and August, 1991 with a total of six respondents. These individuals had varying degrees of administrative experience in mainstream mental health and social services. The fields represented by these individuals included child welfare, community mental health, education, immigration, and psychiatry. The pretesting was conducted with three of the five members of the advisory group, as well as a regional coordinator for educational services with the provincial government, an area service director with the Winnipeg School Division #1, and a dean at Red River Community College who was also a member of the thesis committee. Two members of the advisory committee were not available at the time of pretesting. It should be noted that there was

a limitation to using members from the advisory group and thesis for pretesting the instrument as they had been involved in the development of the instrument, and were aware of the intent of the questions.

The time required to administer the instrument during pretesting was an average of 27 minutes, with a range of 23 to 32 minutes. No respondent reported finding the telephone interview process frustrating.

The changes made to the questionnaire as a result of the pretesting procedure included a reordering of several questions in order to ensure a better sequencing of open and close-ended questions throughout the survey instrument. In addition, two questions were removed to reduce the overall time required to administer the survey instrument. The two items chosen were seen as overlapping with other questionnaire items that addressed the hypotheses, descriptive questions, and comparative questions that were formulated prior to pre-testing. One of these items was a close-ended question and was written as follows: "When taking into account all of the issues which your organization faces, how interested are you in working with other mental health service providers to increase accessibility of services to immigrants and refugees?" The second item that was removed was open-ended and asked: "What do you believe are the major problems an immigrant or refugee experiences?".

Additional changes to the survey instrument included improving the position of page breaks and adding a procedure to reduce response confusion for the respondent. It became apparent during pre-testing that respondents had difficulty remembering the close-ended response options on question 24. A procedure was therefore added in which the

respondent was asked to record the possible response choices on a piece of paper in order to aid his/her recall. Lastly, the format of one question pertaining to the percentage of bilingual staff was changed from closed to open-ended in order to provide the respondent with more freedom in his/her response, and to yield more precise data.

Research Questions and Hypotheses

The present study focused on several descriptive, comparative, and correlational questions related to accessibility of mainstream mental health and social services by immigrants and refugees. The descriptive questions are provided below with a listing of the specific items from the telephone survey instrument which pertain to each question. The entire survey instrument is found in Appendix C.

1. What are the characteristics of the agencies surveyed and the services which they provide?

   Items: #26 (type of funding)
   #29 (number of professional staff)
   #30 (number of volunteer staff)
   #16 (percent of bilingual staff)
   #28 (age range of clients)
   #27 (number of clients per year)
   #31 (type of service: community based versus institutional)
   (public sector versus private sector)

2. What are the characteristics of the respondents?

   Items: #32 (sex)
   #33 (age range)

#34 (country of birth)

#35 (educational level)

3. How do respondents define the terms "immigrant" and "refugee"?

   Items: #3.1 (definition of immigrant)

   #3.2 (definition of refugee)

4. What is the level of service utilization by immigrants and refugees?

   Items: #8.1 (percent of present client population)

   #8.2 (information on intake forms)

   #9 (changes in percent over past 10 years

   #13.5 (percent of immigrants and refugees who complete service)

   #13 (means to identify clients)

5. What plans have been developed by mainstream mental health and social service providers?

   Item: #12 (specific plans)

   #12.1 (plans have been implemented)

6. To what extent have agency policies been established to address issues of accessibility?

   Item: #11 (presence of established policies)

7. What is the role of evaluation in the implementation of agency plans?

   Items: #12.2 (plans that have been evaluated)

   #12.3 (results of evaluation)

8. What barriers exist regarding service program implementation?

   Items: #7 (difficulties making services more accessible)

#25 (use of funds for increasing accessibility)

#18.1 to #18.8 (procedures to lower barriers)

#17 (access to qualified interpreters)

#17.1 (languages with interpreters available)

9. What are the attitudes of agency managers?

   Item: #1 (attributions regarding most significant cause of language barrier)

10. What are the beliefs of agency managers?

    Items: #2 (barriers that impede service provision)

    #24.1 to #24.4 (uniqueness of immigrant and refugee problems)

    #24.5 and #24.6 (adequacy of the service system)

    #5 (system's interest to increase accessibility)

The study also examined the descriptive questions by categorizing the employing organizations of respondents into the following typologies for comparative analysis, with the specific items identified.

Typologies

1. Public sector versus private (voluntary) sector
2. Community based versus institutional services

   Items: #31 (outpatient - community based; inpatient, with or without outpatient services)

The comparative questions addressed the similarities and differences in the functioning of these organizations. The comparative questions follow, with the specific items identified.

1. Do the plans developed by mainstream agencies differ for each typology?

Item: #12 (specific plans)

2. Do agency policies addressing issues of accessibility differ for each typology?

   Item: #11 (presence of established policies)

3. Is there a greater emphasis placed on the role of evaluation for each typology?

   Items: #12.2 (plans that have been evaluated)

   #12.3 (results of evaluation)

4. Are there barrier differences at the service program implementation level for each typology?

   Items: #7 (difficulties making services more accessible)

   #25 (use of funds for increasing accessibility)

   #18.1 to #18.8 (procedures to lower barriers)

   #17 (access to qualified interpreters)

5. Do managerial attitudes differ for each typology?

   Item: #1 (attributions regarding most significant cause of language barrier)

6. Do managerial beliefs differ for each typology?

   Items: #2 (barriers that impede service provision)

   #24.1 to #24.4 (uniqueness of immigrant and refugee problems)

   #24.5 and #24.6 (adequacy of the service system)

   #5 (system's interest to increase accessibility)

7. Do definitions of immigrant and refugee differ for each typology?

   Items: #3.1 (definition of immigrant)

   #3.2 (definition of refugee)

8. Are there differences in utilization of services by immigrants and refugees for each typology?

   Items: #8.1 (percent of present client popultation)

   #9 (changes in percent over past 10 years)

   #13.5 (percent who complete services)

Several hypotheses were tested with the understanding that the cross-sectional survey method utilized in this study cannot determine causal ordering. Despite this limitation, various correlations between variables were investigated and the hypotheses were as follows:

1. Specific planning activities related to access will be positively associated with greater service utilization.

   Items: #12 (specific plans) with

   #8.1 (percent of present client population)

   #9 (changes in percent over past 10 years)

   #13.5 (percent who complete services)

   #12.1 (plans have been implemented) with

   #8.1 (percent of present client population)

   #9 (changes in percent over past 10 years)

   #13.5 (percent who complete services)

2. Favourable managerial attitudes toward immigrants and refugees will be associated with attempts to decrease barriers to access at the service delivery level.

   Items: #1 (system responsible for language barriers) with

   #18.1 to #18.7 (procedures to lower barriers)

3. Immigrant and/or refugee board membership will be positively associated with attempts at the planning level to lessen the

barriers to service. (Note: Respondents from the public sector were not included in the statistical analysis, as government departments do not have boards.)

Items: #19 (ethnic background of board) with

#12 (specific plans)

#12.1 (plans have been implemented)

#12.2 (plans have been evaluated)

4. Service providers that have a means of identifying and tracking immigrant and refugee clients will have more procedures in place to increase cultural accessibility than those providers that do not identify immigrant and refugee status.

Items: #8.2 (information on intake forms) with

#18.1 to #18.8 (procedures to lower barriers)

#13 (means to identify clients) with

#18.1 to #18.8 (procedures to lower barriers)

5. Service providers that have bilingual staff and/or which utilize interpretive services will have a greater proportion of immigrants and refugees among their clients than those which offer services in only the English language.

Items: #16 (percent of bilingual staff) with

#8 (percent of present client population)

#17 (access to interpreters) with

#8 (percent of present client population)

#18.6 (telephone reception only in English) with

#8 (percent of present client population)

It should be noted that the sixth hypothesis was developed

subsequent to the collection of the data and was not part of the original research design.

6. Service providers that hold beliefs that immigrants and refugees have unique problems which can make it more difficult to access services will have made more attempts to decrease barriers at the service implementation level.

   Items: #24.1 to #24.4 (problems of immigrant/refugee) with #18.1 to #18.7 (procedures to lower barriers)

Variables

The variables measured in this study essentially fall into five domains. They are as follows: organizational functions of planning, service program implementation, evaluation, attitudes and beliefs toward service to immigrants and refugees, and suggestions for improvement.

Planning was measured in the following items:

Items: #12 (the presence of specific plans)
#12.1 (plans have been implemented)

Organizational access was a variable in the planning domain which applied only to those organizations with boards. Organizational access was measured as follows:

Items: #19 (ethnic background of board)

Three variables that were contained within the domain of service program implementation were barriers, client tracking, and bilingual and interpretive services. Barriers were assessed on the following questionnaire items:

Items: #7 (difficulties making services more accessible)
#25 (use of funds to increase accessibility)

#18.1 to #18.8 (procedures to lower barriers)

Client tracking was assessed as follows:

Items: #8.1 (percent of present client population)

#8.2 (information on intake forms)

#9 (changes in percent over past 10 years)

#13 (means to identify clients)

#13.5 (percent who complete services)

The items on the questionnaire measuring bilingual staff and interpretive services were as follows:

Items: #16 (percent of bilingual staff)

#17 (access to qualified interpreters)

#17.1 (languages with interpreters available)

The third domain in the investigation was evaluation and the following items were used to obtain a cursory measure of evaluation of planning efforts:

Items: #12.2 (plans that have been evaluated)

#12.3 (results of evaluation)

The fourth domain in this study was the attitudes and beliefs of the respondents toward services to immigrants and refugees. The attitudes of the respondents were evaluated in item 1 which measures the respondents' attributions of the cause of language barriers. The assumption was that respondents who perceive the most important barrier to be the lack of interpreters at an organization or lack of a shared language between client and staff will view the service system as the cause of the language difficulty with immigrants and refugees. However, respondents who perceive the most important language barrier to be the

client who does not speak English will view the client as the reason for the language obstacle.

The beliefs of the respondents were measured in the areas of barriers that impede service provision, the service system's interest in increasing accessibility to this population, the existence of unique problems which hinder access, and the adequacy of the service system. These areas were assessed on the following items:

Items: #2 (barriers that impede service provision)
#5 (service system interest to increase accessibility)
#24.1 to #24.4 (uniqueness of immigrant and refugee problems)
#24.5 and #24.6 (adequacy of the service system)

Analysis

The information collected from the mental health and social service providers in this study was analyzed using descriptive, comparative, and correlational statistical and qualitative methodologies.

Open-ended responses were assigned to inductively developed categories. An interrater reliability assessment was conducted to ascertain the extent to which the qualitative data could be accurately coded for subsequent analysis. A table of random numbers (Babbie, 1973) was utilized to select 20 cases from the total sample. These 20 cases had a combined total of 500 open-ended responses that were independently coded by the present author and another individual in the mental health field. A 92% agreement was found between the two raters ($Z=19.09$, $N=500$, $p<.01$).

The close-ended and open-ended responses were coded and tabulated on the survey instrument for analysis using the Statistical Package for the Social Sciences (SPSS) (Norusis, 1990) program.

In order to describe the variables examined in this study, frequency tables, basic statistical measures of central tendency (mean) and dispersion (variance) were utilized. The comparative analysis between types of organizations relied upon the use of the following nonparametric statistical tests: chi square (X^2), Fisher's Exact Probability Test, and the Mann-Whitney U test. In addition, when statistical significance was obtained, nonparametric measures of association were utilized and included the phi coefficient, uncertainty coefficient, and Cramer's V. The analysis of hypotheses regarding relationships among variables utilized chi square tests of independence, the Mann-Whitney U test, Spearman rank-order correlations, and independent sample t-tests when interval continuous variables were included.

The author also employed strategies discussed by Patton (1987) to analyze and interpret the qualitative data. Six respondents who gave lengthier responses were used as key informants and represented four community based organizations and two institutional organizations. Additionally, two of these organizations were from the public sector and four were from the private sector. An inductive analysis was used to ascertain whether there were any common patterns, themes, or typologies that emerged from the data. Direct quotations from the respondents' comments were used to support particular themes where appropriate.

The missing variables in the study are presented in Appendices D

and E, and were excluded from the analysis. In some situations, the number of cases missing was more than 5% of the sample (see Appendix D). Estimates of these variables may be biased, and tests of association and difference may not be representative of the total sample. Fifteen (17%) of the cases had more than 5% of the applicable variables missing (see Appendix E) and will therefore have exerted minimal influence on the findings.

Limitations of Study

There appear to be several weaknesses in the present study that are worthy of discussion. First, research has found that cross-sectional surveys do not provide data which are intensive or in-depth, or provide control over internal validity factors (Tripodi, 1983). A more intensive examination of the present topic would have included face-to-face interviews with the service providers, an examination of evaluation reports, on-site examinations of the organizations in relation to barriers to service, and attempts to obtain actual data related to client tracking. Tripodi also reported that a further weakness to this design is that cause and effect knowledge and causal ordering cannot be produced.

A perspective not represented in this study was access to services from the viewpoint of the immigrant and refugee population. As noted earlier, an attempt was made to recruit a past consumer of mainstream mental health and social services as part of the study's advisory group, but this was not successful. In addition to this weakness, an adequate assessment of this issue was not possible as the study did not include a detailed investigation from the perspective of the immigrant and refugee

client population. Thus, information collected in this study came from the source of the service administrator with the client's perspective not being evaluated.

The lack of control over a variety of extraneous variables can have effects on the validity of the findings reported in the present study. McGuigan (1978) defined extraneous variables as "variables in an experimental or nonexperimental study that may operate freely to influence the dependent variables. Such variables need to be controlled or otherwise seriously considered in order to not invalidate the study" (pp. 480-481).

Several extraneous variables that were not controlled or measured in this study are worthy of identification and elaboration. First, the adequacy of the level of funding which an organization could utilize in order to provide effective service program implementation was not measured. The presence of funding cuts to the operation of the organization could result in staff layoffs, increased caseloads of program staff, longer waiting lists for service, limited hours of agency operation, and limitations placed on outreach services to the community. This phenomenon alone can affect barriers and access to services. It was not measured and may have confounded the effects on the variables being examined.

Another factor that can have an effect on the variables examined is the adequacy of services offered by mainstream mental health and social service organizations. An assessment of this issue should include input from the client population. Essentially, the survey findings provided a management perspective on service implementation to

the immigrant and refugee population residing in Winnipeg. The information provided by managerial respondents could not be verified and some of these respondents may have tried to present the best possible picture of their agency despite anonymity.

The attitude dimension was not fully assessed with respect to its effects on access as the investigation did not include the attitudes of the staff providing direct interventions with the client or those of the immigrant and refugee population.

Despite these limitations, and the fact that the present investigation was essentially an exploratory study, the survey findings should be extremely useful in highlighting service providers' views of immigrants' and refugees' access to mental health and social services in Winnipeg. The perspective of the mental health and social service administrator provided an initial examination of the variables that can effect accessibility to an agency's services. The reported viewpoints of these management staff may act as a catalyst for organizations within the mental health and social service network to critically examine their own organizational processes in order to improve organizational and client accessibility.

The present survey contributed additional knowledge on the importance of administrative functions within the organization with regard to the accessibility of services to immigrants and refugees, and on the broader issue of networking practices between mental health, social service organizations and ethno-specific community organizations. In addition, information was also analyzed with respect to data collection (e.g. client tracking), and attitudes of managerial staff and

possible effects on accessibility to agency services.

The present study may provide direction for the enhancement of service delivery practices to the immigrant and refugee population by stimulating future research efforts that address the areas noted in the limitations section of this report. In addition, researchers might wish to replicate the present study in Winnipeg and/or another North American city in order to confirm or refute the findings presented in this study.

IV. FINDINGS

Introduction

The findings from the present study are presented in this chapter in three sections. The first section deals with descriptive findings, the second section with the comparative findings, and the third section discusses the findings associated with the six hypotheses of the study.

Descriptive Findings

1. Organizational Characteristics

As indicated in Table 4, the respondent organizations surveyed were approximately evenly divided between institutional (inpatient) services that also offer community based services (45%) and those that offer solely community based services (49%). The number of respondent organizations offering only inpatient services was much smaller (6%). Overall, the number of respondents from the public sector (12%) was considerably smaller than that from the private sector (88%).

TABLE 4

ORGANIZATIONS BY TYPE OF SERVICE

(N=85)

Type of service	No.	% of valid responses
Community based	41	49
Institutional and community-based	37	45
Institutional	5	6
	83[a]	100
Government/public sector	10	12
Private sector	75	88
	85	100

[a]Two respondents refused to specify type of service.

The description of the funding sources of the organizations is presented in Table 5. Respondents were asked to identify which of the following four specific categories of funding applied to their organizations: federal/provincial government, municipal government, charitable, and private. "Charitable" referred to funding from registered charitable organizations, while "private" referred to donations or grants from other private donors. An opportunity was also given to respond with "other" in order to provide respondents with additional flexibility in the range of sources they identified.

TABLE 5

FUNDING SOURCES

(N=85)

	Frequency	% of organizations
Federal/provincial	82	97
Charitable	35	41
Other	24	28
Private	21	25
Municipal	20	23

Note. Respondents were permitted to report more than one source. Placement in each of the categories was made by the respondents.

The major sources of funding for these organizations were the federal and provincial governments (97%). Examples of funding sources cited by respondents as being in the "other" category include funding for specific organizational projects, foundation grants, and fund-raising. It should be noted that some of the sources assigned by the respondents as being "other" may fall into one of the four specified categories.

Table 6 details the distribution of organizations according to the number of clients served annually. It indicates that over 50% of the respondents represented organizations that provided services to more than 1,000 clients on an annual basis.

TABLE 6

TOTAL CLIENTS PER YEAR

(N=85)

No. of clients	Frequency	%
1. Less than 100	5	6
2. 101 to 500	22	26
3. 501 to 1,000	14	16
4. Over 1,000	44	52
	85	100

Table 7 describes the total number of volunteers and professional staff. It can be noted that the majority of the respondents were from organizations that had less than 30 volunteers (60%) and less than 30 professional staff (66%).

TABLE 7

VOLUNTEER AND PROFESSIONAL STAFF

(N=85)

Volunteers	Frequency	% of valid responses
1. Less than 10	34	41
2. 10 to 30	16	19
3. 31 to 100	16	19
4. Over 100	17	21
	83[a]	100

Professional staff	Frequency	% of valid responses
1. Less than 10	28	33
2. 10 to 30	28	33
3. 31 to 100	17	20
4. Over 100	12	14
	85	100

[a]Two respondents answered "Do not know".

In Table 8, data are provided about the age ranges served by the respondent's organizations. The study population contained a high percentage of agencies serving each age group.

TABLE 8

AGE RANGE OF CLIENTS

(N=85)

Client ages	Frequency	% of organizations
0 to 18 years	62	73
19 to 65 years	76	89
Over 65 years	65	76

Note. Respondents could report more than one age range.

Table 9 provides the data about the percentage of staff reported to be bilingual (including, but not limited to, the English and French combination). The majority of the respondents (73%) reported that 30% or less of their staff were bilingual.

TABLE 9

PERCENT OF STAFF REPORTED TO BE BILINGUAL

(N=81)[a]

Percentage of staff	Frequency	% of valid responses
0	9	11
1-10	29	36
11-30	21	26
31-49	9	11
Over 50	13	16
	81	100

[a]Four respondents answered "Do not know".

2. Respondent Characteristics

Of the 85 respondents who completed the questionnaire on behalf of their organizations, 62% (N=53) were female. The age range of the most respondents was 31 to 50 years (N=65, 76%), with 20% (N=17) being over 50 years old and 4% (N=3) being under 30 years old.

Table 10 provides a list of the respondents' locations of birth. As expected, most (79%) were born in Canada.

TABLE 10

RESPONDENT LOCATION OF BIRTH

(N=85)

Location of Birth	Frequency	%
Canada	67	79
U.S.A.	6	7
U.K.	4	5
Africa	2	2
Germany	2	2
Israel	1	1
Philippines	1	1
El Salvador	1	1
Poland	1	1
	85	99[a]

[a]Percentage totals less than 100 due to rounding errors.

The respondents were primarily from English and/or French speaking countries, with 92% being born in countries in which English or French is a primary spoken language.

In Table 11, information is provided about the respondents'

educational qualifications. Seventy-two percent (N=85) of respondents possessed a Bachelor's or Master's university degree. Furthermore, an additional 15% (N=13) had earned a doctorate or medical degree.

TABLE 11

EDUCATIONAL QUALIFICATIONS

(N=85)

Highest level of education	Frequency	%
High school diploma	3	3
Community college (2 year)	5	6
Some university	2	2
Bachelor's degree	31	37
Master's degree	31	37
Doctorate	8	9
MD, MD Fellow	5	6
	85	100

3. Immigrant and Refugee Definitions

The definitions of "immigrant" provided by the respondents generally fell into two themes. The first theme related to the immigrant's use of a voluntary, planned immigration process. This theme was referenced by 74% (N=63) of the respondents and included descriptions of immigrants as those who had freely chosen to come to Canada and had followed a planned process. Some respondents also mentioned that immigrants are newcomers or first generation Canadians.

The second theme evolving from the respondents' definitions was based upon the specification of immigration procedures and regulations. This theme was evident in definitions provided by 26% (N=22) of

respondents. Examples of respondent definitions included immigrants seeking landed immigrant status and/or citizenship, applying through an embassy, and being accepted into a country according to a quota system.

The definitions of "refugee" revolved around four themes. The first theme was that a refugee was an individual who left his/her country on an involuntary basis and/or had been in an unsafe living situation. The majority (80%, N=68) of the respondents' definitions were consistent with this theme. The respondents described refugees as having a lack of choice in leaving their homelands, being in a life-threatening situation or being persecuted. Refugees were also described as fleeing from their countries of origin and needing safer living conditions as a result of war or political problems. This theme also included a definition of someone with more immediate needs (e.g. basic living) and who was in "bigger trouble than the immigrant".

A second theme evident from the definitions was an emphasis placed on immigration procedures. Fourteen percent (N=12) of the respondents made statements related to this theme. For example, refugees were described as being landed immigrants, with permission granted based upon refugee status. This theme also included references to refugees being accepted into the receiving country for humanitarian reasons.

The third theme related to the respondents' use of specific terminology established by Employment and Immigration Canada. A small proportion of the respondents (4%, N=3) stated some aspect of Employment and Immigration Canada's criteria. One respondent stated that there were two types of refugees: one type of refugee will "claim refugee status, whereas the other type claims refugee status and is legitimately

here for safety reasons". This respondent seemed to be referring to the conventional and designated types within the refugee classification described in Chapter II. Another respondent described a refugee as someone who has a special category of status and must meet certain defined criteria to obtain status.

The fourth, least common theme apparent in the definitions relates to refugees being described as individuals who had few contacts and supports during the process of fleeing from their homeland. This theme was evident in only 2% (N=2) of the respondents' definitions.

4. Service Utilization by Immigrants and Refugees

The definition for "immigrants and refugees" as specified in Chapter II, and on the telephone survey, was used for determining rates of their service utilization. As described in Table 12, the majority of the respondents (72%, N=56) indicated that 1 to 10% of their client population was made up of immigrants and refugees. The second most frequent response (given by 11% of the respondents, N=9) was that none of their clients were immigrants and refugees.

It should be noted that the definition utilized for "immigrants and refugees" would have resulted in an underestimation of the number of immigrants and refugees using mental health and social services. This is a result of the fact that the study's definition eliminates immigrants and refugees who could speak English or French upon arrival in Canada, or who have lived in Canada for more than ten years.

TABLE 12

PROPORTION OF CLIENTS WHO ARE IMMIGRANTS AND REFUGEES

N=78[a]

Proportion	Frequency	% of valid cases
1. 0%	9	11
2. 1 to 10%	56	72
3. 11 to 30%	8	10
4. 31 to 50%	2	3
5. Over 50%	3	4
	78	100

[a]Seven respondents answered with "Do not know".

Sixty-two of the 78 respondents (81%) estimated their proportions of immigrants and refugees as clients, whereas 16 respondents (19%) indicated that their proportions were based on information obtained on intake forms. (Respondents had been asked whether the proportion they cited was an estimate or based on information from intake forms.)

However, in response to a separate question about client identification, 54% of all 85 respondents (N=46) reported having a means to identify whether a client was an immigrant or a refugee. Respondents often reported that an immigrant's or refugee's status was determined during either the intake or interview process with direct service personnel.

The majority of the respondents (68%) reported an increase in the percentage of services to immigrant and refugee clients at their organizations during the past 10 years. These findings are presented in Table 13.

TABLE 13

PERCENTAGE OF SERVICES TO IMMIGRANTS AND REFUGEES

(N=79)[a]

Change over the past 10 years	Frequency	% of valid responses
Decreased	3	4
Stayed the same	22	28
Increased somewhat	35	44
Increased significantly	19	24
	79	100

[a]Six respondents answered "Do not know".

Sixty-two of 85 respondents (73%) were unable to specify the proportion of their immigrant and refugee clients who actually complete services. Of these 62 respondents, 39 (63%) had not been asked about the completion of services because their organizations had no means to determine whether a client was an immigrant and/or a refugee, and 23 respondents (37%) were not able to provide an estimate. The 23 respondents who indicated that they did have a means to determine status but could not give an estimate were not asked to give a reason for their "do not know" responses in the questionnaire. However, some of the respondents offered explanations related to offering only assessment, placement, or drop-in services to clients. One respondent stated that the question did not apply to his/her organization indicating that clients receive services when requested.

The remaining 23 of the 85 respondents were able to estimate the proportion of immigrants and refugees who complete their services. However, the distribution of the data with regard to the estimates of

the retention rates for immigrants and refugees was skewed. The median proportion of clients completing services was 90%, and the proportion completing services at the 25th, 50th, and 75th percentiles were 65%, 90%, and 100% respectively. The estimates ranged from 0 to 100%.

5. Established Policies

When respondents were asked about the existence of agency policies that address issues of accessibility, 21% (N=17) stated that organizational policies had already been established. Thus, 79% of the respondents (N=65) indicated that their organizations had no specific policies in place to facilitate an increase of accessibility by immigrants and refugees. Table 14 provides a description of the responses regarding the extent to which organizational policies for improving access to services are in existence.

TABLE 14

ORGANIZATIONAL POLICIES TO INCREASE ACCESS

(N=82)[a]

Status	Frequency	% of valid responses
Policies do not exist	47	57
Being considered	17	21
Being developed	1	1
Policies exist	17	21

[a]Two respondents answered "Do not know"; one respondent refused to answer.

6. Plans Developed by Organizations

Following the close-ended question about the existence of established policies, respondents were asked to describe specific plans

that had been developed to improve access to services by immigrants and refugees. The majority of the respondents (55%, N=47) related that their organizations had not developed any plans. Of the 38 providers (45%) whose agencies had developed plans to increase access, all but one respondent reported that their plans had been implemented. The plans that had been developed were categorized (by inductive means) into the following areas: changes to established policies, staff/service changes, staff training, and networking/outreach activities. Some respondents reported plans in more than one area.

The plans related to policies were those considered to be organization-wide and comprehensive. With regard to changes to established policies, one respondent noted a plan to have board representation include immigrants. Another respondent reported having established policies that pertain to obtaining interpreters, but did not indicate that any changes had been made to services.

Examples of plans in the area of staff/service changes included offering flexible hours of agency operation, hiring staff proficient in languages other than English and French, and creating new programs for immigrants and refugees in the areas of employment, housing, neighbourhood support, and family therapy. An additional service change reported was the production of a multilingual video that introduced clients to an agency's services.

A third area of planning included the provision of staff training on cultural awareness and sensitivity. Cultural training was offered to staff by internal agency staff members, as well as by outside ethnocultural groups. In one agency, a two-day workshop had been

offered to its staff.

Plans reported in the area of networking and outreach included increasing staff membership on committees with a mandate to address issues of service access by immigrants and refugees, developing specific initiatives to increase contacts with immigrant serving agencies, offering educational programs to immigrants and refugees in local churches, employing a staff whose role is to network with other community organizations, and offering an agency's facilities for use by other ethnocultural groups.

In Table 15, data are provided with respect to the distribution of reported plans among these four areas.

TABLE 15

ORGANIZATIONAL PLANS

(N=38)

Plans	No.	% of respondents
Staff/service changes	20	53
Network/outreach activities	20	53
Staff training	9	24
Changes to established policies	2	5

Note. Some respondents reported plans in more than one area.

Organizations which have developed plans related to accessibility of services by immigrants and refugees tend to focus on the areas of staff/service changes and networking/outreach activities. Only 9 (24%) of the 38 respondents identified plans in the area of training for staff on cross-cultural issues. Similarly, only 2 (5%) of the 38 respondents had developed plans pertaining to the establishment of policies. Thus,

plans for specific staff changes, service changes, and networking appear to be developed without comprehensive organization policies. It should be noted, however, that 89% of the 85 respondents had reported that their organizations provided cross-cultural training opportunities for their staff when asked questions not related to planning. This difference appears to be related to having cross-cultural training opportunities in place without having any plans for training in the future.

7. Evaluation of Agency Plans

As noted earlier, 55% (N=47) of respondents had not developed any plans to address accessibility issues pertaining to immigrants and refugees. Thus, 38 (45%) of respondents had developed some plans. However, 62% (N=23) of these 38 respondents indicated that their organization's plans had not been evaluated. In addition, one (3%) of the 38 respondents did not know if an evaluation had been conducted. As a result, only 14 respondents (17%) reported that their organizational plans had been evaluated.

The evaluations of the plans which were reported by the 14 respondents were categorized on an inductive basis into four areas: policies, staff/service changes, staff training, and network/outreach activities. Table 16 provides an analysis of the results of the evaluations.

TABLE 16

RESULTS OF EVALUATIONS REGARDING ORGANIZATIONAL PLANS

(N=14)[a]

Planning area	Positive	Somewhat Positive	Negative	Evaluation In progress
Policies	0	0	0	0
Staff/service changes	8	0	0	2
Staff training	2	0	0	0
Network/outreach	1	0	0	2
Total	11	0	0	4

[a]One respondent indicated that more than one plan had been evaluated.

Of the plans that are developed and evaluated, 100% (n=11) were described as having a positive result. Examples included a noted increase to access of services by refugees and positive responses from clients and staff. One respondent reported that his/her organization had received accreditation for hiring of staff who are culturally sensitive and who speak a variety of languages. (The details of the accreditation were not provided.)

Table 17 describes the frequency with which plans have been evaluated.

TABLE 17

FREQUENCY OF EVALUATIONS OF ORGANIZATIONAL PLANS

(N=38)[a]

Planning area	Evaluated	Not evaluated
Policies	0	2
Staff/service changes	10	10
Staff training	2	7
Network/outreach	3	17
	15	36

[a]Some respondents reported plans in more than one area, and one respondent reported that two plans had been evaluated.

The data appear to indicate that organizations tend to make their greatest efforts to complete evaluations in the area of staff/service changes. At the policy level, the results appear to indicate that evaluations are not conducted. However, no significant difference in the evaluation of plans between the extreme categories of policies and staff/service changes was found when Fisher's exact test was conducted (p=.48). In addition, staff training and outreach activities are generally not evaluated.

8. Barriers to Making Services Culturally Accessible

The barriers that were identified by the 85 respondents were categorized inductively into the areas of planning, service implementation, attitudes, and evaluation. The respondents' perceptions with regard to difficulties in these four areas are provided in Table 18.

TABLE 18

DIFFICULTIES IN INCREASING ACCESSIBILITY

(N=85)

Domains	Frequency	%
Service implementation	71	85
Planning	21	25
Attitudes	12	14
Evaluation	1	1

Note. Some respondents reported difficulties in more than one domain.

The definition of barrier, as noted in Chapter II, was utilized for each of the four domains. Respondents' descriptions of planning barriers related to their experiences when developing initiatives aimed to achieve a change in the future state of affairs. Barriers at the service implementation level related to difficulties in the "follow through" of actually putting services into place. In the evaluation domain, barriers were identified in the analysis of new interventions, monitoring of program implementation, and the assessment of established programs. Attitudinal barriers were those that related to respondents views about immigrants and refugees (e.g. "the evaluative nature of staff towards certain types of individuals" which appears to reflect racism).

The majority of the respondents (N=71, 85%) perceived that the primary difficulties in making their services more accessible to immigrants and refugees were at the service implementation level. Several respondents reported that at this level there are language difficulties as a result of the lack of available interpreters to assist

staff. Specifically, one respondent stated that the lack of "staff speaking the language and being culturally sensitive" was a major barrier. In addition, direct care staff were reported to lack knowledge of what services are available in the community to which to refer immigrant and refugee clients. Several respondents noted that more time is required to provide cross-cultural interventions which increases delays in the provision of services to all clients.

At the planning level, difficulties were noted by 25% (N=21) of the respondents. Issues at this level included the organization's lack of planning related to hiring culturally appropriate staff, and networking and outreach efforts. Staff and client attitudes were specified as problematic by 14% (N=12) of the respondents. Examples of staff attitudes included "prejudice and racism by everyone including social service staff" and "attitudinal problems by staff in multicultural aspects". With respect to attitudes about clients, examples included immigrant and refugee distrust of government organizations and legally mandated services. The area of evaluation was mentioned by only one (1%) of the 85 respondents. When asked to elaborate on the stated evaluation difficulties, this service administrator described his/her organization as having limited time to provide services to clients let alone conduct evaluations.

Solutions to barriers. Respondents also provided their viewpoints on how their organizations would use additional funding if such monetary resources were ever made available. This information was categorized into the areas of planning, service program implementation, evaluation, and responses reflecting attitudes. Table 19 provides an overview of

the areas in which this funding would be utilized.

TABLE 19

AGENCY USE OF EXTRA FUNDING

(N=85)

Domains	Frequency	%
Implementation	68	80
Planning	39	46
Attitude issues	8	9
Evaluation	4	5

Note. Some respondents reported more than one use.

As noted above, the majority of respondents would utilize the extra funds to address accessibility issues at the service implementation level. Some of the potential initiatives suggested by the respondents included hiring more culturally appropriate staff, setting up culturally sensitive training programs for all staff, creating videos in a variety of languages that describe services and staff roles, and increasing the number of interpreters.

A variety of suggestions were made at the planning level. Examples of planning initiatives included those pertaining to rendering specific treatment more culturally sensitive, community based programs that are not treatment oriented but instead focus on immigrant and refugee adaptation to Canada, and advocacy services in the community. One respondent stated that he/she would advocate for the development of one centralized service where all immigrants and refugees could have all their needs met. This service was viewed as being established by Employment and Immigration Canada as it has an obligation to set up

employment and housing services to this population. Another respondent stated that his/her agency would attempt to make the board more representative of immigrants and refugees by improving outreach efforts. Strengthening linkages with ethnocultural groups in order to "jointly tackle the problem through planning and developing more appropriate services" was also suggested.

Issues in the attitude domain were reflected in 9% (N=8) of the service providers' responses. Several respondents stated they would not pursue or accept the extra funding. One respondent stated "we would not use the money as we haven't had the need to service this population". Another respondent described this as a hypothetical question by stating that at this point his/her organization did not need the money. Other respondents gave similar statements indicating that "it's not a category that we would need the money for", it was of "low priority", and "we wouldn't take the money as we don't take refugees who don't speak English". The lack of desire to provide services to this population is apparent in these statements.

The use of funding for research and evaluation purposes was identified by only 5% (N=4) of the 85 respondents. One respondent gave an example of an evaluation activity as conducting an "internal project" (not elaborated upon) prior to hiring culturally appropriate staff. Another respondent reported that his/her organization would conduct a needs assessment by liaising with other community groups. Other uses mentioned for the funds were "sponsoring research into mental health delivery systems that work for different populations" and examining ways to deal with immigrant and refugee mistrust of government and mental

health services.

The implementation of a number of solutions to barriers that were reported in the literature was examined by asking respondents to rate the extent to which specific descriptions applied to their organizations. Table 20 lists these organizational arrangements to address barriers and the extent to which they were applied.

TABLE 20

ORGANIZATIONAL ARRANGEMENTS TO ADDRESS BARRIERS

(N=85)

Organizational arrangement	(1) Never		(2) Sometimes		(3) Often		(4) Always		M	(SD)
	N	(%)	N	(%)	N	(%)	N	(%)		
1. Staff training (N=84[a])	9	(11)	56	(67)	16	(19)	3	(3)	2.15	(.65)
2. Adequate networking for management (N=84[a])	10	(12)	46	(55)	20	(24)	8	(9)	2.31	(.81)
3. Adequate networking for staff (N=85)	1	(1)	43	(50)	31	(37)	10	(12)	2.59	(.71)
4. Staff collaborate with clergy (N=82[b])	9	(11)	49	(60)	16	(19)	8	(10)	2.28	(.79)
5. Staff collaborate with folk healers (N=82[b])	42	(51)	32	(39)	8	(10)	0	(0)	1.58	(.67)
6. Telephone reception only in English (N=85)	23	(27)	2	(2)	4	(5)	56	(66)	3.09	(1.33)
7. Answering machine used at organization (N=85)	47	(55)	22	(26)	7	(8)	9	(11)	1.74	(1.00)
8. Client reach staff via receptionist (N=84[a])	3	(4)	25	(30)	17	(20)	39	(46)	3.09	(.95)

Note. Percentages refer only to valid responses.

[a]One respondent answered "Do not know".

[b]Two respondents answered "Do not know"; one respondent refused to answer.

The organizational arrangements listed in Table 20 can be categorized into three areas: staff training (Item 1), networking (Items 2-5), and

telephone reception services (Items 6-8). With regard to staff training, 89% of the respondents indicated that they provided at least some opportunities for staff to obtain culturally sensitive training. Adequate networking between ethno-specific organizations and management staff was perceived as occurring at least some of the time by 88% of the respondents. Almost all (99%) of the respondents reported adequate networking to some extent between ethno-specific organizations and service delivery staff. Collaboration between clergy and service delivery staff was reported to occur by 89% of the respondents, whereas collaboration with traditional folk healers was reported by only 49% of the respondents. In the area of telephone reception, 66% of the respondents reported English-only telephone service. The use of an answering machine at organizations was reported by 89% of the respondents. In addition, the majority of the respondents (66%) indicated that clients are required to utilize a telephone receptionist often or always in establishing contact with direct service staff.

The barrier of not having access to qualified interpreters was also assessed. Seventeen percent of the respondents reported that they never had access to qualified interpreters, 39% had some access, 21% had access most of the time, and 23% reported always having access to interpreters. Thus, 83% of the respondents did have at least some access to qualified interpreters. The specific languages for which qualified interpreters were available are provided in Table 21.

TABLE 21

LANGUAGES AND THE AVAILABILITY OF INTERPRETERS

(N=85)[a]

Language	N	%
Polish	63	74
Spanish	62	73
Vietnamese	55	64
Portuguese	53	62
Tagalog	52	61
Cantonese	50	58
Laotian	43	51
Hindi	38	45
Other[b]	62	73

[a]Some respondents reported the availability of interpreters in more than one language.

[b]The category of other includes French and Aboriginal languages.

9. Attitudes Regarding Linguistic Barriers

This attitude dimension examined causal attributions regarding the linguistic barriers that can affect access to an organization's services. Each respondent was asked to assign responsibility for the presence of linguistic barriers and the data are provided in Table 22.

TABLE 22

RESPONSIBILITY FOR LINGUISTIC BARRIERS

(N=79)[a]

Nature of responsibility	N	% of valid responses
System responsible		
Staff do not speak client's language	37	47
Lack of interpreters at agency	18	23
Client responsible		
Client does not speak English	24	30

[a]Four respondents answered "Do not know"; two respondents refused to answer.

The data from Table 22 indicate that 70% of the respondents believe that the service system is responsible for the linguistic barriers that hinder access to services by immigrants and refugees.

10. Beliefs about Barriers

Respondents were asked about their beliefs regarding the barriers that impede the provision of services to immigrants and refugees. The barriers were categorized into the following four themes which were identified from the responses: societal, mental health and social service system, organizational, and client. The frequency with which the barriers reflected these themes is presented in Table 23.

TABLE 23

BARRIERS TO SERVICE PROVISION

(N=85)

Barrier theme	N	%
Societal	5	6
System	13	15
Organizational	68	80
Client	36	42

Note. Some respondents provided more than one barrier.

The majority of the respondents (80%) reported that mental health agencies and social service organizations were the major factor hindering the provision of services to immigrants and refugees. The barriers within this category included unavailability of interpreters and appropriate staff language capacity. Several respondents noted problems using interpreters with immigrant and refugee clients. These reported problems were consistent with those reviewed in Chapter II. For example, one respondent stated that "the assumption is they can do treatment, but they can't". He/she additionally stated that "interpretation is not possible when translating". This respondent appeared to be referring to issues arising from interpreters' lack of mental health training and difficulties providing cultural interpretation simultaneously with translation of words. Several respondents reported other problems using interpreters such as the lack of disclosure of information by clients, immigrants feeling intimidated if they cannot speak English, interpreters having difficulty translating professional terminology, interpreter bias, and the lack of

professional, confidential interpreters. Problems were also noted when clients select interpreters such as relatives, and one respondent stated that relatives may not have significantly superior English language capacity than the clients.

Several additional organizational barriers were reported by the respondents. One organizational barrier reported was related to staff not being culturally sensitive. Statements by respondents revealed the belief that staff have a lack of "cultural understanding, and what it means to be an immigrant" and lack cultural awareness of their needs. One respondent noted the lack of "understanding of cultural norms such as child abuse versus the ritual of dealing with fever". Another respondent reported that cultural issues were less of a barrier than the language issues. The attitudes of staff toward immigrants and refugees were another organizational barrier that was cited. Examples from respondents included "staff that value other groups", "racism", and an "unconscious prejudice toward certain groups". Another barrier noted by one respondent was that "community agencies are not often open after work hours, nights, or on weekends when immigrants might need them".

The second most prevalent theme attributed barriers to the immigrant and refugee client. Specific issues for immigrants and refugees, according to the respondents, were "the stigma of mental health for some cultures", "their knowledge of available services", "being suspicious of government agencies", and "an overdetermined reaction by immigrants and refugees to large bureaucratic organizations". An additional respondent noted that some barriers arise as a result of the lack of priority given to mental health needs by the

client in comparison to needs for "jobs, housing, and learning the language".

System barriers identified by respondents included the lack of services available to immigrants and refugees in the generic mental health system (which creates additional financial barriers for clients who seek services outside the generic public system), and the perception that the mental health system in general is fragmented and uncoordinated. One respondent reported a lack of networking in the community among organizations. Another respondent indicated that there are "systemic barriers which don't make programs and services appropriate". Finally, another respondent reported that institutions are reluctant to change standards which would allow for the hiring of individuals with professional qualifications obtained in a foreign country.

Societal barriers were specified by a few respondents. One respondent stated "the immigrant and refugee client does not have faith that he will be understood. We as Canadians have not given them data to allow for faith to develop." Another respondent noted the lack of funding options available to assist organizations in facilitating their accessibility of services.

Beliefs about immigrant and refugee problems. The beliefs of the respondents regarding the uniqueness of immigrant and refugee problems are reported in Table 24.

TABLE 24

BELIEFS ABOUT IMMIGRANT AND REFUGEE PROBLEMS

(N=85)

Problem[a]	1		2		3		4		5		M	(SD)
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)		
Difficulty conveying mental disorder	13	(15)	7	(8)	14	(17)	25	(29)	26	(31)	3.52	(1.40)
Do not seek service as fear deportation	1	(1)	4	(5)	14	(16)	37	(44)	29	(34)	4.05	(.90)
Lack of English is major barrier (N=84)[b]	5	(6)	8	(10)	7	(8)	18	(21)	46	(55)	4.10	(1.25)
Distrust of agencies	0	(0)	6	(7)	19	(22)	42	(50)	18	(21)	3.84	(.84)

Note. Percentages refer only to valid responses.

[a]The existence of problems was rated according to the scale 1=Strongly disagree, 2=Mildly disagree, 3=Neither agree nor disagree, 4=Mildly agree, 5=Strongly agree.

[b]One respondent answered "Do not know".

The majority of the respondents agreed that each of these problems exist for the immigrants and refugees. Sixty percent (N=51) of the respondents agreed that immigrants and refugees have difficulty conveying sensations of mental disorder to staff, 78% (N=66) indicated that immigrants and refugees do not seek mental health services for fear of deportation, 76% (N=64) acknowledged that the lack of a working knowledge of the English language is a major barrier to service delivery, and 71% (N=60) agreed that immigrants and refugees are distrusting of mental health agencies. The belief for which there was

the greatest variation in the responses related to difficulties experienced conveying mental disorders to staff. Twenty-three percent (N=20) of the respondents disagreed with this statement. Significantly fewer respondents endorsed the view that immigrants and refugees experience difficulties in conveying mental disorders to staff (Mean Rank=24.70) in comparison to the more highly endorsed belief of immigrant and refugee distrust of agencies (Mean Rank=38.64) using the Wilcoxon Rank-Test for dependent populations (Z=-1.83, N=85, p=.03 [one-tailed]).

Beliefs about the service system. The respondents' beliefs about the adequacy of the service system are described in Table 25, with the same rating scale used as in Table 24.

TABLE 25

BELIEFS ABOUT ADEQUACY OF SERVICE SYSTEM

(N=85)

Beliefs[a]	1		2		3		4		5		M	(SD)
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)		
Lack of interpreters is a major barrier	4	(5)	5	(6)	12	(14)	26	(30)	38	(45)	4.05	(1.12)
Services are adequate (Winnipeg)	42	(50)	27	(32)	14	(16)	2	(2)	0	(0)	1.72	(0.82)

[a]The existence of beliefs was rated according to the scale 1=Strongly disagree, 2=Mildly disagree, 3=Neither agree nor disagree, 4=Mildly agree, 5=Strongly agree.

With regard to the lack of interpreters at mental health organizations, 75% of the respondents agreed that this was a major barrier to service

delivery to immigrants and refugees. Furthermore, 82% of the respondents agreed that the mainstream mental health services provided to immigrants and refugees in Winnipeg were not adequate to meet the population's needs.

Table 26 provides data about the respondents' perceptions of the system's level of interest in increasing accessibility of services to immigrants and refugees.

TABLE 26

SYSTEM'S INTEREST IN INCREASING ACCESSIBILITY

(N=81)[a]

Level of interest	N	% of valid responses
1 Not interested	8	10
2 Somewhat interested	38	47
3 Very interested	26	32
4 Very interested and willing to dialogue	9	11

[a]Three respondents answered "Do not know"; one respondent refused to answer.

M=2.44; *SD*=0.82

Overall, the respondents believe that the system's interest in increasing accessibility is between somewhat interested and very interested.

Comparative Findings

Institutional versus Community Based Organizations

As noted in Table 4, 51% (N=42) of the respondents were from institutional organizations (most of which also offered services to non-

residents) while 49% (N=41) were from community based organizations. (Two respondents refused to answer the question pertaining to this categorization). Thus, the number of respondents were approximately equally divided among these two types of organizations.

No statistically significant differences were found at the $p \leq .05$ level for the majority of the comparative questions specified in Chapter III (see Tables 27 to 35). However, one finding from comparative question 8 pertaining to utilization of services by immigrants and refugees did result in statistical significance at the $p \leq .01$ level (see Table 36). Community-based respondents reported significantly higher percentages of immigrants and refugees as present clients than respondents from institutional organizations. No significant differences were found between these types of respondents in the other two areas of utilization (i.e. services provided to immigrants and refugees during the past 10 years, and immigrants and refugees who complete services).

Although none of the differences from other questions reached significance at the $p < .05$ level, some general patterns are worthy of discussion. The findings from comparative question 1 (Table 27) indicated a trend toward the more frequent occurrence of the development of plans focusing on accessibility issues at community based organizations than at institutional settings. Overall, 51% of the respondents from community based organizations had such plans while this was the case for only 36% of respondents from institutional agencies. In both types of organizations the plans that are primarily being developed tend to focus on the same areas of concern: service

implementation and community networking. One finding from comparative question 4 pertaining to greater networking by staff with clergy (Table 31) approached significance in favour of institutional over community based organizations. This finding may be a result of the fact that some institutional organizations offer pastoral services within their organizations which would likely facilitate networking with clergy.

TABLE 27

PLANNING: INSTITUTIONAL VERSUS COMMUNITY BASED RESPONDENTS

(N=83)

Planning area	% of respondents Institutional (N=42) Yes	No	Community based (N=41) Yes	No	X^2	d.f.	p
Policies	2.4	97.6	2.4	97.6	-	1	1.00[b]
Service changes	16.7	83.3	29.3	70.7	1.22[a]	1	.27
Staff training	11.9	88.1	9.8	90.2	-	1	1.00[b]
Network/outreach	16.7	83.3	31.7	68.3	1.80[a]	1	.18
None established	64.3	35.7	48.8	51.2	1.44[a]	1	.22

[a]Continuity correction.

[b]Fisher's Exact Test.

TABLE 28

AGENCY POLICIES: INSTITUTIONAL VERSUS COMMUNITY BASED RESPONDENTS

(N=81)

Organization type	% of respondents reporting policies				U	d.f.	p[a]	Mean Rank
	Yes	Developing	Considering	None				
Institutional (N=41)	20	0	17	63	735.5	3	.37	41.44
Community based (N=40)	23	2	23	53	735.5	3	.37	41.56

[a]Two-tailed.

TABLE 29

EVALUATION OF PLANS: INSTITUTIONAL VERSUS COMMUNITY BASED RESPONDENTS

	% of respondents				N	X^2	d.f.	p
	Institutional (N=15)		Community based (N=21)					
Existence of evaluation	Yes	No	Yes	No				
Plans evaluated	40	60	33	67	36	.003[a]	1	.95

Area of evaluation	Mean Rank Institutional	Mean Rank Community based	N[b]	U	d.f.	p[c]
Policies	1.50 (N=1)	1.50 (N=1)	2	.5	4	1.00
Service changes	8.75 (N=6)	9.14 (N=11)	17	31.5	4	.87
Staff training	4.50 (N=4)	4.50 (N=4)	8	8.0	4	1.00
Network/outreach	11.00 (N=5)	8.92 (N=13)	18	25.0	4	.25

[a]Continuity correction.

[b]Some respondents reported evaluations in more than one area.

[c]Two-tailed.

TABLE 30

BARRIERS: INSTITUTIONAL VERSUS COMMUNITY BASED RESPONDENTS

Difficulties increasing access	% of respondents Institutional (N=41) Yes	No	Community based (N=41) Yes	No	N	X^2	d.f.	p
Planning	24.4	75.6	26.8	73.2	82	.000[a]	1	1.00
Service implementation	82.9	17.1	85.4	14.6	82	.000[a]	1	1.00
Evaluation	0	100.0	2.4	97.6	82	[b]	1	1.00
Attitudes	12.2	87.8	17.1	82.9	82	.097[a]	1	.75
None	0	100.0	2.4	97.6	82	[b]	1	1.00
Hypothetical funding	(N=40)		(N=40)					
Planning	37.5	62.5	57.5	42.5	80	2.46[a]	1	.12
Service implementation	82.5	17.5	85.0	15.0	80	.000[a]	1	1.00
Evaluation	0	100.0	10.0	90.0	80	[b]	1	.12
Attitudes	12.5	87.5	5.0	95.0	80	[b]	1	.43

[a]Continuity correction.

[b]Fisher's Exact Test.

TABLE 31

ORGANIZATIONAL ARRANGEMENTS:

INSTITUTIONAL VERSUS COMMUNITY BASED RESPONDENTS

Arrangement	Institutional N	Institutional Mean Rank	Community based N	Community based Mean Rank	N	U	d.f.	p[a]
Training for staff	82	38.74	42	44.40	40	724.0	3	.19
Management networks with ethnocultural	82	40.60	42	42.45	40	802.0	3	.70
Line staff networks with ethnocultural	83	38.76	42	45.32	41	725.0	3	.17
Use of clergy	80	44.32	41	36.49	39	643.0	3	.09
Use of folk healers	80	40.45	40	40.55	40	798.0	3	.98
English only phone	83	44.29	42	39.66	41	765.0	3	.29
Answering machine	83	39.67	42	44.39	41	763.0	3	.32
Receptionist to reach staff	82	42.60	41	40.40	41	795.5	3	.65
Interpreter access	82	41.44	42	41.56	40	837.5	3	.98

[a]Two-tailed.

TABLE 32

MANAGERIAL ATTITUDES: INSTITUTIONAL VERSUS COMMUNITY BASED RESPONDENTS

Attitude	% of respondents Institutional (N=40) System	Client	Community based (N=38) System	Client	N	X^2	d.f.	p
Attribution of language barrier	75.0	25.0	63.2	36.8	78	.787[a]	1	.37

[a]Continuity correction.

TABLE 33

MANAGERIAL BELIEFS ABOUT BARRIERS:

INSTITUTIONAL VERSUS COMMUNITY BASED RESPONDENTS

Belief	Institutional N	Institutional Mean Rank	Community based N	Community based Mean Rank	U	d.f.	p[a]
Difficulties conveying mental disorder	83	45.17	42	38.76	728.0	4	.21
Fear deportation	83	41.71	42	42.29	849.0	4	.90
Lack of English is major barrier	82	40.75	42	42.29	808.5	4	.74
Clients distrust	83	42.06	42	41.94	858.5	4	.98
Lack of interpreters is barrier	83	41.32	42	42.70	832.5	4	.78
Services adequate	83	43.43	42	40.54	801.0	4	.55
System interest to increase access	79	40.99	40	38.99	740.5	3	.68

[a]Two-tailed.

TABLE 34

MANAGERIAL BELIEFS ABOUT SOURCE OF BARRIERS:

INSTITUTIONAL VERSUS COMMUNITY BASED RESPONDENTS

	% of respondents							
	Institutional (N=42)		Community based (N=41)		N[c]	X^2	d.f.	p
Source	Yes	No	Yes	No				
Society	2.4	97.6	9.8	90.2	83	[b]	1	.20
System	14.3	85.7	17.1	82.9	83	.002[a]	1	.96
Organization	76.2	23.8	82.9	17.1	83	.238[a]	1	.63
Client	38.1	61.9	48.8	51.2	83	.578[a]	1	.45

[a]Continuity correction.

[b]Fisher's Exact Test.

[c]Two respondents refused to answer type of organization.

TABLE 35

DEFINITIONS: INSTITUTIONAL VERSUS COMMUNITY BASED RESPONDENTS

	% of respondents							
	Institutional (N=42)		Community based (N=41)		N[c]	X^2	d.f.	p
Question	Volunt.	Imm.proc.	Volunt.	Imm.proc.				
Definition of immigrant	76.2	23.8	73.2	26.8	83	.009[b]	1	.95
Definition of refugee cited:	Yes	No	Yes	No				
Involuntary process	88	12	73	27	83	2.08	1	.15[b]
Immigration process	10	90	17	83	83	.47	1	.49[b]
Canada Immigration	2	98	5	95	83	-	1	.62[a]
Level of readiness	0	100	5	95	83	-	1	.24[c]

[a]Fisher's Exact Test.

[b]Continuity correction.

[c]Two respondents refused to answer type of organization.

TABLE 36

UTILIZATION BY IMMIGRANTS AND REFUGEES:

INSTITUTIONAL VERSUS COMMUNITY BASED RESPONDENTS

Question	Institutional Mean Rank	N	Community based Mean Rank	N	N[a]	U	d.f.	p
% of clients	33.77	40	43.75	36	76	531.0	4	.01[††]
Past 10 years of services provided	37.08	39	40.97	38	77	666.0	3	.41

	Institutional (N=14)		Community based (N=9)			Separate[c] variance estimate		
	M	*SD*	M	*SD*	N[b]	t	d.f.	p
% who complete services	82.50	23.92	68.33	37.08	23	1.02	21	.33

[a]Excludes respondents who answered "Do not know".

[b]Excludes respondents who answered "Do not know", refused, or were screened out.

[c]Separate variance was used as the variances were different for the two groups.

[††]$p \leq .01$, two-tailed.

Public versus Private Sector Organizations

The survey question identifying the funding arrangements for organizations proved to be unproductive in delineating the respondents into public and private sector organizations. The vast majority of the respondents (97%) reported securing funds from federal and/or provincial governments thus placing most organizations in the same category. However, when the list of respondents was reexamined by the author in conjunction with the thesis advisor, only 10 of the 85 respondents were

found to be from the public sector, while 75 respondents were from organizations in the private sector.

Despite the unequal sample sizes of the public and private sector groups, a primary concern in the present analysis relates to the small size of the public sector group. The small size of this group makes it more difficult to locate true differences (i.e. increased risk of Type II errors) because of the lack of sufficient statistical power.

One of the findings from comparative question 1 (Table 37) was statistically significant ($p<.01$) with a greater percentage of public sector respondents indicating plans being developed at the service implementation level. However, the strength of association between these two variables was weak. No significant differences were obtained in the other areas of planning that were explored (policy, staff training, community networking, and the existence of organizational plans across all categories to increase access).

TABLE 37

PLANNING: PRIVATE VERSUS PUBLIC SECTOR RESPONDENTS

(N=85)

Planning area	% of respondents				X^2	NPAR CORR	d.f.	p
	Private sector (N=75)		Public sector (N=10)					
	Yes	No	Yes	No				
Policies	2.7	97.3	0	100.0	[a]	-	1	1.00
Service changes	18.7	81.3	60.0	40.0	[a]	.09[b]	1	.01[++]
Staff training	9.3	90.7	20.0	80.0	[a]	-	1	.29
Network/outreach	22.7	77.3	30.0	70.0	[a]	-	1	.69
None established	60.0	40.0	30.0	70.0	[a]	-	1	.09

[a]Fisher's Exact Test.

[b]Uncertainty coefficient.

[++]$p \leq .01$, two-tailed.

Comparative question 2 (see Table 38) which addressed the presence of established policies to improve access to services was affirmed by 50% of the public sector respondents and 17% of the private sector respondents.

TABLE 38

AGENCY POLICIES: PRIVATE VERSUS PUBLIC SECTOR RESPONDENTS

(N=82)

Organization type	% of respondents reporting policies				U	d.f.	p	Mean Rank
	Yes	Developing	Considering	None				
Public (N=10)	50	10	20	20	180.0	3	.004[++]	59.50
Private (N=72)	17	0	21	62	180.0	3	.004[++]	39.00

[++]$p < .01$, two-tailed.

No significant differences were noted between the public and

private respondents with regard to the role of evaluation (comparative question 3; Table 39). Nonparametric tests of statistical difference were not computed in the evaluation area of policies between the private and public sectors as none of the respondents in the public sector reported evaluations in this area.

Evaluation was not generally identified as a priority for either type of organization. However, there are some differences in the priorities among different evaluation areas. For example, respondents appear to attribute less importance to the evaluation of policies and staff training than to service changes and network/outreach activities.

TABLE 39

EVALUATION OF PLANS: PRIVATE VERSUS PUBLIC SECTOR RESPONDENTS

	% of respondents							
	Private sector (N=29)		Public sector (N=8)		N	X^2	d.f.	p
Existence of evaluation	Yes	No	Yes	No				
Plans evaluated	31.0	69.0	62.5	37.5	37[b]	[a]	1	.22

Area of evaluation	Mean Rank Private sector		Mean Rank Public sector		N	U	d.f.	p[c]
Service changes	9.88	(N=13)	8.50	(N=5)	18[b]	27.5	4	.59
Staff training	4.83	(N=6)	3.50	(N=2)	8[b]	4.0	4	.38
Network/outreach	9.20	(N=15)	11.00	(N=3)	18[b]	18.0	4	.41

[a]Fisher's Exact Test.

[b]Some respondents had been screened out.

[c]Two-tailed.

The findings from comparative question 4 (summarized in Table 40) indicated no significant differences between the public and private sector respondents in their perceptions of the primary difficulties in

making their services more culturally accessible, or in the proposed uses cited for additional funding to increase access.

TABLE 40

BARRIERS: PRIVATE VERSUS PUBLIC SECTOR RESPONDENTS

Difficulties increasing access	% of respondents Private sector (N=74) Yes	No	Public sector (N=10) Yes	No	N	X^2	d.f.	p
Planning	25.7	74.3	20.0	80.0	84	[a]	1	1.00
Service implementation	83.8	16.2	90.0	10.0	84	[a]	1	1.00
Evaluation	1.4	98.6	0	100.0	84	[a]	1	1.00
Attitudes	16.2	83.8	0	100.0	84	[a]	1	.34
None	0	100.0	10.0	90.0	84	[a]	1	.12
Hypothetical funding	(N=72)		(N=10)					
Planning	48.6	51.4	40.0	60.0	82	[a]	1	.74
Service implementation	83.3	16.7	80.0	20.0	82	[a]	1	.68
Evaluation	5.6	94.4	0	100.0	82	[a]	1	1.00
Attitudes	11.1	88.9	0	100.0	82	[a]	1	.59

[a]Fisher's Exact Test.

Statistically significant differences between the private and public sector respondents were found in the areas of staff training pertaining to cultural sensitivity, providing telephone reception in English only, clients' reaching of staff through a telephone receptionist, and having ready access to qualified interpreters (see Table 41). In the area of cultural training for staff, 100% of the public sector respondents stated that at least some training was provided for staff, while this was the case with 88% of the private sector respondents.

The data indicated that English was the only language utilized at the telephone reception level by 20% of the public sector respondents and by 72% of the private sector respondents. Fifty-one percent of the respondents from the private sector reported that clients always reached service staff through the telephone receptionist, while this was indicated by only 10% of the public sector respondents. In addition, 100% of the public sector respondents, and 81% of the private sector respondents, indicated that they had at least some access to qualified interpreters. Thus, the private sector tends to rely more on the use of the English language at the point of initial contact by the client (i.e. telephone reception) than those organizations in the public sector.

TABLE 41

ORGANIZATIONAL ARRANGEMENTS:

PRIVATE VERSUS PUBLIC SECTOR RESPONDENTS

	Private sector		Public sector				
Arrangement	N	Mean Rank	N	Mean Rank	U	d.f.	p
Training for staff	84	40.70	75	57.50	202.5	3	.02†
Management networks with ethnocultural	84	41.36	74	50.90	286.0	3	.20
Line staff networks with ethnocultural	85	41.61	75	53.40	271.0	3	.12
Use of clergy	82	41.47	72	41.70	358.0	3	.97
Use of folk healers	82	41.66	73	40.17	316.5	3	.84
English only phone	85	45.75	75	22.35	168.5	3	.0007††
Answering machine	85	42.74	75	44.95	355.5	3	.77
Receptionist to reach staff	84	45.51	74	20.20	147.0	3	.0009††
Interpreter access	84	40.30	74	58.80	207.0	3	.02†

†$p<.05$, two-tailed. ††$p<.01$, two-tailed.

The differences between the public and private sector respondents' attitudes in attributing linguistic barriers to the service system or the client were found to approach significance at the .06 level (see Table 42). The client's inability to speak English was identified as the barrier most responsible for hindering access to services by 60% of the public sector respondents and 26% of the private sector respondents.

TABLE 42

MANAGERIAL ATTITUDES: PRIVATE VERSUS PUBLIC SECTOR RESPONDENTS

	% of respondents							
	Private sector (N=69)		Public sector (N=10)		N	X^2	d.f.	p
Attitude	System	Client	System	Client				
Attribution of language barrier	73.9	26.1	40.0	60.0	79	[a]	1	.06

[a]Fisher's Exact Test.

With regard to beliefs, the only area in which those of public sector respondents differed significantly from private sector respondents related to the level of interest in increasing accessibility of services to immigrants and refugees demonstrated by service providers (see Tables 43 and 44). Ninety percent of the public sector respondents indicated that mental health and social service providers would be very interested in working with other service providers for this purpose, while this was reported by only 37% of the private sector respondents.

TABLE 43

MANAGERIAL BELIEFS ABOUT BARRIERS:

PRIVATE VERSUS PUBLIC SECTOR RESPONDENTS

	Private sector		Public sector				
Belief	N	Mean Rank	N	Mean Rank	U	d.f.	p
Difficulties conveying mental disorder	85	42.77	75	44.70	358.0	4	.81
Fear deportation	85	41.93	75	51.05	294.5	4	.24
Lack of English is barrier	84	41.24	74	51.85	276.5	4	.15
Clients distrust	85	43.52	75	39.10	336.0	4	.57
Lack of interpreters is barrier	85	44.38	75	32.65	271.5	4	.13
Services adequate	85	42.99	75	43.05	374.5	4	.99
System interest to increase access	81	38.60	71	58.05	184.5	3	.008††

††$p<.01$, two-tailed.

TABLE 44

MANAGERIAL BELIEFS ABOUT SOURCE OF BARRIERS:

PRIVATE VERSUS PUBLIC SECTOR RESPONDENTS

	% of respondents							
	Private Sector (N=75)		Public sector (N=10)		N	X^2	d.f.	p
Source	Yes	No	Yes	No				
Society	4.0	96.0	20.0	80.0	85	[a]	1	.10
System	16.0	84.0	10.0	90.0	85	[a]	1	1.00
Organization	80.0	20.0	80.0	20.0	85	[a]	1	1.00
Client	42.7	57.3	40.0	60.0	85	[a]	1	1.00

[a]Fisher's Exact Test.

With regard to the definitions of "immigrant" and "refugee", there were no significant differences in the themes between public and private sector respondents. The findings pertaining to these definitions are provided in Table 45.

TABLE 45

DEFINITIONS: PRIVATE VERSUS PUBLIC SECTOR RESPONDENTS

	% of respondents						
	Private sector (N=75)		Public sector (N=10)		N	d.f.	p[a]
Question	Volunt.	Imm.proc.	Volunt.	Imm.proc.			
Definition of immigrant	76.0	24.0	60.0	40.0	85	1	.28
Definition of refugee cited:	Yes	No	Yes	No			
Involuntary process	81	19	70	30	85	1	.41
Immigration process	12	88	30	70	85	1	.14
Canada Immigration	4	96	0	100	85	1	1.00
Level of readiness	3	97	0	100	85	1	1.00

[a]Fisher's Exact Test.

No significant differences were found on comparative question 8 between the private and public sector respondents with regard to utilization of services by immigrants and refugees (see Table 46).

TABLE 46

UTILIZATION BY IMMIGRANTS AND REFUGEES:

PRIVATE VERSUS PUBLIC SECTOR RESPONDENTS

Question	Private sector Mean Rank	N	Public sector Mean Rank	N	N[a]	U	d.f.	p[d]
% of clients	38.69	71	47.71	7	78	191.0	4	.20
Past 10 years of services provided	39.21	69	45.45	10	79	290.5	3	.39

	Private sector (N=20)		Public sector (N=3)			Separate[c] variance estimate		
	M	*SD*	M	*SD*	Nb	t	d.f.	p[d]
% who complete services	76.25	30.30	81.67	31.75	23	-.29	21	.77

[a]Excludes respondents who answered "Do not know".

[b]Excludes respondents who answered "Do not know", refused, or were screened out.

[d]Two-tailed.

Hypotheses Findings

Six hypotheses pertaining to the accessibility of mental health and social services by immigrants and refugees were assessed in the present study, and the findings are presented in Tables 47 through 54. The hypotheses were assessed by evaluating the results utilizing nonparametric tests of difference and correlation as the questionnaire items included nominal and/or ordinal scales. However, where interval data were available, parametric tests of difference and correlation were conducted.

Planning Activities and Service Utilization

The findings pertaining to hypothesis 1 are presented in Table 47.

Hypothesis 1 was: Specific planning activities related to access will be positively associated with greater service utilization. Significance was found for two of the three variables that measured service utilization. These two variables were the percentage of immigrants and refugee as clients (U=617, d.f.=4, p=.04) and the percentage of services provided to immigrants and refugees during the past 10 years (U=538.5, d.f.=3,p=.007). On these two variables, respondents with organizational plans had significantly greater mean ranks than respondents who reported having no organizational plans. No significant difference was found regarding the third variable which was the percentage of immigrant and refugee clients who complete services.

TABLE 47

HYPOTHESES FINDINGS: PLANNING TO INCREASE ACCESS

Survey question	Mean Rank: Plans	Mean Rank: No plans	N[a]	U	d.f.	p
Plans with:						
% of clients	43.36	36.19	78	617.0	4	.04[t]
Services in past 10 years	46.61	34.74	79	538.5	3	.007[tt]
% of clients with:						
Plans in policy area	37.50	39.55	78	72.0	4	.43
Plans re service changes	51.03	36.04	78	332.5	4	.001[tt]
Plans to train staff	45.50	38.81	78	232.0	4	.16
Plans to network/outreach	39.80	39.40	78	574.0	4	.47
Past 10 years' services with:						
Plans in policy area	43.00	39.96	79	36.0	3	.44
Plans re service changes	57.21	34.55	79	243.0	3	.0001[tt]
Plans to train staff	45.83	39.25	79	262.5	3	.19
Plans to network/outreach	44.79	38.48	79	479.0	3	.13

	% complete services: Plans M	Plans SD	No plans M	No plans SD	N[b]	Separate[c] variance est. t	d.f.	p
% complete services with:								
Plans to increase	85.50	19.06	70.38	35.32	23	-1.31	21	.10
Plans in policy area	-	-	76.95	29.80	23	-	23	-
Plans re services	92.14	10.74	70.31	33.19	23	-2.36	21	.01[tt]
Plans for training	88.33	20.20	75.25	31.01	23	-.96	21	.20
Plans to network	85.00	17.79	75.26	31.86	23	-.85	21	.21

[a]Excludes "Do not know" responses.

[b]Excludes those who said "Do not know", refused, and were screened out.

[c]This was used as the variances were different for the two groups.

[t]$p \leq .05$, one-tailed. [tt]$p \leq .01$, one-tailed.

The area of planning where statistical significance was obtained was the service implementation level with respect to the percentage of immigrants and refugees as clients (U=332.5, d.f.=4, p=.001), the percentage of services provided to immigrants and refugees during the past ten years (U=243, d.f.=3, p=.0001) and the percentage of immigrant and refugee clients who complete services (t=-2.36, d.f.=21,p=.01). Respondents from organizations with plans at the service implementation level had significantly higher mean ranks for the first two variables and a significantly greater mean score on the third variable than respondents who reported not having service implementation plans established. This finding indicates greater service utilization by immigrants and refugees in organizations that report having plans at the service implementation level. Planning that focused on policy development, staff training, and community networking with regard to greater service utilization failed to reach statistical significance at the conventional level for any of the three variables.

Managerial Attitudes and Barrier Reduction

Hypothesis 2 was stated as follows: Favourable managerial attitudes toward immigrants and refugees will be associated with attempts to decrease barriers to access at the service delivery level. The findings are presented in Table 48. In the vast majority of areas, favourable managerial attitudes were not found to be significant with regard to attempts to decrease barriers. However, respondents who had favourable and unfavourable attitudes towards immigrants and refugees approached significant differences for service staff contact with traditional folk healers (U=505, d.f.=3, p=.05). Respondents who

indicated that the system was responsible for linguistic difficulties had significantly higher mean ranks suggesting greater contacts between service staff and traditional folk healers than respondents who assigned responsibility to clients. This finding supported the hypothesis of favourable attitudes being associated with attempts to decrease barriers to access.

TABLE 48

HYPOTHESES FINDINGS: FAVOURABLE ATTITUDES

Survey question	Mean Rank System	Mean Rank Client	N[a]	U	d.f.	p
Attribution of language barrier responsibility with:						
Training for staff	38.85	41.04	78	597.0	3	.32
Management network	37.90	43.33	78	544.5	3	.14
Service staff network	39.86	40.31	79	652.5	3	.46
Staff collaborate clergy	40.21	36.33	77	572.0	3	.22
Staff use folk healers	41.47	33.54	77	505.0	3	.05[t]
Telephone only English	40.31	39.29	79	643.0	3	.41
Answering machine	41.25	37.15	79	591.5	3	.21
Receptionist reaches staff	37.69	43.56	78	550.5	3	.13

[a]Excludes respondents who answered "Do not know.

[t]$p \leq .05$, one-tailed.

Board Membership and Barrier Reduction

Hypothesis 3 was stated as follows: Immigrant and/or refugee board membership will be positively associated with attempts at the planning level to lessen the barriers to service. The findings are presented in Table 49 and indicate that the hypothesis was not

supported. A significant difference in the opposite direction for board membership and plans being developed at the service implementation level was obtained (X^2=3.43, d.f.=1, p=.03). Respondents who reported that their boards did not have ethnic representation were found to have significantly higher percentages of plans pertaining to access at the service implementation level than respondents who indicated their boards had ethnic representation. The strength of association between board representation and plans for service implementation was weak. It should be noted, however, that the survey question pertaining to board representation asked respondents to indicate if their boards were representative of the communities served. It is possible that the hypothesis was confounded by information about the respondents' level of knowledge regarding the ethnic composition of their communities and boards.

No significant differences were obtained for immigrant and refugee board membership to overall plans developed, or planning efforts in staff training, implementation, or evaluation. However, planning efforts in the areas of policy development and community networking approached significance. Most of the nonsignificant differences are in the opposite direction than hypothesized.

TABLE 49

HYPOTHESES FINDINGS: BOARD MEMBERSHIP

Survey question	Representation % plan	Representation % no plan	No representation % plan	No representation % no plan	N[a]	X^2	d.f.	p
Ethnic board membership with:								
Plans to increase	36.7	63.3.	54.8	45.2	72[d]	1.62[b]	1	.10
Plans evaluated	36.4	63.6	45.5	54.5	33[c]	[e]	1	.36
Plans implemented	100.0	0	95.7	4.3	34[c]	[e]	1	1.00
Plans in policy	6.7	93.3	0	100.0	72[d]	[e]	1	.09
Plans re services[f]	13.3	86.7	35.7	64.3	72[d]	3.43[b]	1	.03[t]
Plans for training	6.7	93.3	14.3	85.7	72[d]	[e]	1	.23
Plans to network	13.3	86.7	31.0	69.0	72[d]	2.11[b]	1	.07

[a]Public sector respondents not included as they do not have boards.

[b]Continuity correction.

[c]Some respondents were screened out.

[d]Excludes respondents who answered "Do not know".

[e]Fisher's Exact Test.

[f]Phi=.25.

[t]$p<.05$, one-tailed.

Client Identification and Cultural Accessibility

Hypothesis 4 was stated as follows: Service providers that have a means of identifying and tracking immigrant and refugee clients will have more procedures in place to increase cultural accessibility than those providers that do not identify immigrant and refugee status. The findings are presented in Table 50. Statistical significance was not obtained regarding differences between respondents whose organizations

utilize intake forms to identify immigrant status and those which do not in relation to having more specific procedures to increase cultural accessibility. However, significance was approached for organizations that acknowledged a means of identifying immigrants and refugees with providing telephone reception to clients in more than the English language ($U=743.0$, $d.f.=3$, $p=.05$). Respondents who had a means to identify immigrants and refugees had significantly smaller mean ranks than respondents reporting English language telephone services. This finding supported the hypothesis of the presence of client tracking with increased cultural accessibility. The frequency of all other procedural arrangements designed to increase cultural accessibility of services by organizations did not differ between organizations which did and did not identify immigrant status.

TABLE 50

HYPOTHESES FINDINGS: MEANS OF IDENTIFYING CLIENTS

Survey question	Mean Rank: Intake form	Mean Rank: Estimate	N	U	d.f.	p
Estimate or intake forms with:						
Staff training	37.73	38.66	76[a]	399.5	3	.43
Management networks	36.00	38.97	76[a]	354.0	3	.32
Service staff networks	41.04	38.59	77[a]	389.5	3	.34
Staff collaborate clergy	38.04	37.99	75[a]	402.5	3	.49
Staff use folk healers	38.92	37.20	74[a]	378.0	3	.38
Telephone only English	41.04	38.59	77[a]	389.5	3	.33
Answering machine	40.12	38.77	77[a]	401.5	3	.41
Receptionist reaches staff	41.15	37.95	76[a]	375.0	3	.30
Means to identify immigrants/ refugees with:	Means	No means				
Staff training	43.97	40.81	84[a]	811.5	3	.24
Management networks	41.39	43.78	84[a]	827.5	3	.31
Service staff networks	45.87	39.62	85	765.0	3	.10
Staff collaborate clergy	42.68	40.07	82[a]	779.5	3	.29
Staff use folk healers	41.81	41.12	82[a]	818.5	3	.44
Telephone only English	39.65	46.95	85	743.0	3	.05[t]
Answering machine	41.27	45.04	85	817.5	3	.22
Receptionist reaches staff	41.26	44.00	84[a]	817.0	3	.29

[a]Excludes respondents screened out and "Do not know" responses.

[t]$p \leq .05$, one-tailed.

Impact of Bilingual Staff and Interpreters

Hypothesis 5 was stated as follows: Service providers that have

bilingual staff and/or which utilize interpretive services will have a greater proportion of immigrants and refugees among their clients than those which offer services in only the English language. The findings are presented in Table 51. Statistical significance was reached with respect to this hypothesis. The relationship of organizational access to interpreters with the percentage of immigrants and refugees as clients was significant and had a high correlation (r_s=.45, N=77, p=.00). Furthermore, bilingual staff and the presence of immigrants and refugees as clients was also significantly and highly correlated (r_s=.39, N=74, p=.00) The relationship of the provision of telephone reception service in languages other than English to the proportion of immigrants and refugees utilizing an organization's services was statistically significant (p=.04) and weak to moderate (r_s=.20). A limitation of the findings is that the language of French was not screened out and the results pertain to a comparison of English only with bilingual and multilingual services to clients.

TABLE 51

HYPOTHESES FINDINGS: BILINGUAL STAFF AND/OR INTERPRETERS

Survey question	N[a]	NONPAR CORR r_s	p
% of immigrant/refugee clients with:			
% of bilingual staff	74	.39	.00[††]
Access to interpreters	77	.45	.00[††]
Telephone in English only	78	-.20	.04[†]

[a]Excludes respondents who answered "Do not know".

[†]p<.05, one-tailed; [††]p<.01, one-tailed.

Unique Client Problems and Barrier Reduction

Hypothesis 6 was stated as follows: Service providers that hold beliefs that immigrants and refugees have unique problems which can make it more difficult to access services will have made more attempts to decrease barriers at the service implementation level. The findings are presented in Table 52. The beliefs of managerial respondents related to the difficulties that immigrant and refugee clients have in conveying mental disorders to staff, speaking English, and trusting mental health agencies reached statistical significance with regard to some specific procedural arrangements at mental health and social service organizations.

TABLE 52

HYPOTHESES FINDINGS: BELIEFS REGARDING ACCESS

Organizational arrangement	Respondent beliefs: Convey r_s	Convey p	Deportation r_s	Deportation p	English r_s	English p	Distrust r_s	Distrust p	N
Staff training	.06	.28	-.06	.29	-.08	.22	.02	.40	84[a]
Management networks	-.12	.13	-.12	.13	-.16	.07	-.01	.47	84[a]
Service staff networks	-.11	.14	-.06	.29	.10	.18	.21	.02[†]	85[b]
Staff collaborate with clergy	.24	.01[††]	.09	.19	.02	.40	.01	.46	82
Staff use folk healers	-.08	.23	-.08	.23	-.02	.42	.06	.30	82
Telephone only in English	-.14	.10	-.01	.46	-.02	.43	-.05	.33	85[b]
Answering machine	-.03	.36	.12	.14	-.06	.28	.04	.35	85[b]
Receptionist reaches staff	-.03	.38	.07	.24	.24	.01[††]	.02	.44	84[a]

[a] N=83 for belief about speaking English.

[b] N=84 for belief about speaking English.

[†] $p<.05$, one-tailed. [††] $p\leq.01$, one-tailed.

The belief that immigrants and refugees have difficulty conveying mental disorders to staff was significantly associated with collaboration by service delivery staff with clergy who know the immigrant or refugee client (r_s=.24, N=82, p=.01). The belief of the lack of English as being a major barrier was signficantly and positively correlated with clients reaching staff through the telephone

receptionist (r_s=.24, N=83, p=.01). This correlation is in the opposite direction of what was hypothesized. Distrust of mental health services was significant and positively correlated to the arrangement of adequate networking of service delivery staff with ethnospecific organizations. All of these relationships which were found to be significant are considered to be weak to moderate.

Summary of findings

The significant differences and associations regarding accessibility of mental health and social services by immigrants and refugees are summarized in Tables 53 and 54.

TABLE 53

SUMMARY OF SIGNIFICANT COMPARATIVE FINDINGS

PRIVATE VERSUS PUBLIC SECTOR

Factor	Finding
Plans at service implementation level	Public sector has significantly more plans ($p=.01^{++}$)[a]
Policies to increase access	Public sector has significantly more policies ($p=.004^{++}$)[b]
Cultural training for staff	Public sector has significantly more training ($p=.02^{+}$)[b]
Telephone reception in English only	Public sector uses significantly less English only ($p=.0007^{++}$)[b]
Telephone reception to reach staff	Public sector has significantly less receptionist use required to reach staff ($p=.0009^{++}$)[b]
Access to interpreters	Public sector has significantly greater access to interpreters ($p=.02^{+}$)[b]
System interest to increase access	Significantly greater system interest in increasing accessibility was reported by the public sector ($p=.008^{++}$)[b]

table continues

INSTITUTIONAL VERSUS COMMUNITY BASED

Factor	Finding
Percent of present clients that are immigrants and refugees	Community based reported significantly higher percentages of immigrants and refugees as clients ($p=.01^{++}$)[b]

[a]Fisher's Exact Test.

[b]Mann-Whitney U Test.

$^{+}p \leq .05$, two-tailed. $^{++}p \leq .01$, two-tailed.

TABLE 54

SUMMARY OF SIGNIFICANT FINDINGS: HYPOTHESES

Hypothesis 1: Planning activities positively associated with greater service utilization.

Findings: Significantly greater percentage of:

- Immigrants and refugees as clients for organizations with planning activities ($p=.04^{*}$)[a].
- Services to immigrants and refugees during the past 10 years for organizations with planning activities ($p=.007^{**}$)[a].
- Immigrants and refugees as clients ($p=.001^{**}$)[a], services to immigrants and refugees during the past 10 years ($p=.0001^{**}$)[a], and immigrant and refugee clients who complete services ($p=.02^{*}$)[b] for organizations who have plans at the service implementation level.

Hypothesis 2: Favourable attitudes positively associated with decrease of barriers.

Finding:

- Significance was approached between attributing system responsibility for linguistic barriers and more frequent contacts between service staff and traditional folk healers ($p=.05^{*}$)[a].

Hypothesis 3: Ethnic board membership positively associated with planning to lessen barriers to access.

Finding:

- Significant inverse relationship found boards that did not have ethnic representation have more plans at service implementation level ($p=.03^{*}$)[c].

table continues

Hypothesis 4: Means of client tracking positively associated with procedures to increase accessibility.

Finding:

- Significance was approached for service providers with a means to identify immigrants and refugees found to offer less telephone reception in English only ($p=.05^{*}$)[a].

Hypothesis 5: Bilingual staff and/or interpreters positively associated with greater proportion of immigrants and refugees as clients.

Finding:

- The presence of bilingual staff ($p=.000^{**}$)[d], access to interpreters ($p=.000^{**}$)[d], and providing telephone reception in more than English ($p=.04^{*}$)[d] were significantly associated with greater proportions of immigrants and refugees as clients than in organizations without these arrangements.

Hypothesis 6: Beliefs of unique problems positively associated with attempts to decrease barriers.

Findings:

- Beliefs of client difficulties conveying mental disorders to staff was significantly associated with greater collaboration between service staff and clergy ($p=.01^{**}$)[d].
- Beliefs that the lack of a working knowledge of English was a major barrier was significantly correlated with greater utilization of a telephone receptionist by clients to reach staff ($p=.01^{**}$)[d].
- The belief that immigrants and refugees distrust mental health services was positively correlated with greater networking between

table continues

service staff and ethnospecific organizations ($\underline{p}$=.02*)[d].

[a]Mann-Whitney U test.

[b]t-test.

[c]Continuity correction.

[d]Spearman's Rank-order Correlation.

*$\underline{p} \leq .05$, one-tailed; **$\underline{p} \leq .01$, one-tailed.

V. DISCUSSION

Chapter 5 presents a discussion of the possible interpretations, explanations, and significance of the major research findings. Areas where the present findings support, or diverge from, previous research are highlighted. Implications for policy and practice are provided, and the relevance of the findings for other service sectors is outlined. The chapter concludes with suggestions for further research.

Descriptive Findings

In the descriptive data, the proportion of immigrants and refugees was reported as being between 1 to 10% of the client population according to the majority of the respondents. However, 11% of the respondents indicated that none of their clients were immigrants or refugees according to the definition used in this study, whereas 17% reported that immigrants and refugees comprised more than 10% of their client population. These variations may reflect differences in the accessibility of organizations for immigrants and refugees, or, particularly for organizations reporting that they had no immigrant or refugee clients, lack of identification of types of clients. In addition, there may be differences based upon the type of service. The findings in this investigation indicate that the presence of bilingual staff, access to interpreters, and the provision of telephone reception in languages in addition to English are significantly associated with greater proportions of immigrants and refugees as clients.

A majority of the respondents reported an increase in the percentage of services being provided to immigrants in the past 10 years. This reported increase in services to immigrants and refugees is consistent with Manitoba's recent gradual increase in the annual immigration (from 4,799 in 1987 to 6,626 in 1990 [Manitoba Culture, Heritage and Citizenship, 1991]), and may also reflect the impact of legislation promoting multiculturalism.

The lack of client tracking capabilities was apparent as 73% of the respondents were unable to provide an estimate of the percentage of immigrants and refugees who actually complete the services that are offered by the organization. This finding suggests that it would be difficult for organizations to assess the usefulness and appropriateness of services being provided to immigrant and refugee clientele as a result of a lack of information about retention. It should be noted that this lack of data pertaining to client tracking may not be confined to immigrants and refugees but may apply to other client populations as well.

With respect to policies aimed at improving access to services by immigrants and refugees, 79% of the respondents indicated that their organizations had no organizational policies in place. In the area of planning, just over half of the respondents acknowledged that their own organizations had not developed any organizational plans to improve access to services by immigrants and refugees. In addition, the evaluation of the plans designed to enhance accessibility of services is not seen as a priority by service providers. Of the respondents who had acknowledged the presence of planning initiatives, only approximately

one fifth reported that these plans had been evaluated. All of the evaluated plans were described as having positive outcomes, with the greatest emphasis placed by service providers on conducting evaluations at the service implementation level. Another indicator as to the lack of importance that evaluation has for service providers was that only 5% of respondents identified evaluation as a way to utilize any additional funding provided to increase accessibility of services to immigrants and refugees. Finally, the existence of specific policies to enhance the ethnic membership on organizational boards was reported by only 1% of the respondents in the present study, which is similar to the findings of 4% of respondents reported by Doyle and Visano (1987) in their study conducted in Metropolitan Toronto. The present lack of planning and evaluation of planning activities, as well as the lack of organizational policies that address ethnic board membership in mainstream organizations implies that the mental health and social service system in Winnipeg is not prepared for the increasing demands for services by immigrants and refugees.

The lack of linguistic access to services by immigrants and refugees is also very apparent from the findings and supports previous research. The descriptive data indicated that the majority (76%) of respondents viewed the lack of a working knowledge of English by the individual seeking service as a major barrier to service provision. Almost one half of the respondents (47%) reported that less than 10% of their staff were bilingual (including the English and French combination). In addition, two thirds of the respondents reported that their organizations provided telephone reception in English only. This

latter finding is somewhat similar to the results of the Doyle and Visano (1987) study in which the majority of the service providers (81%) offered information to the public in only the English language. However, the Doyle and Visano study was concerned with information about services being provided through both verbal and written means. This may account for the larger percentage obtained by them. The finding related to telephone reception in the present study is critical as frequently the first contact a potential client has with an organization is with the receptionist.

However, linguistic accessibility to services appears to improve after the immigrant and refugee client has had the initial contact with the telephone receptionist. Eighty-three percent of the respondents acknowledged having some access to interpreters to assist in the provision of their services to immigrants and refugees. This finding is considerably higher than the 54% reported in the Quan (1987) investigation conducted in Texas. However, in the Quan study access to interpreters was analyzed according to the ethnicity of the respondent which was not done in the present study, and thus the findings may not be directly comparable.

The issue of cultural sensitivity training for staff has also previously been identified in the literature as an important activity for improving access (Doyle and Visano, 1987). In the present study, 89% of the respondents reported that opportunities are provided for this type of staff training. This finding is considerably higher than the finding of 45% in the Doyle and Visano (1987) investigation. The difference in these findings may be related to the fact that the Doyle

and Visano study asked respondents about the existence of staff training policies rather than the the actual provision of training opportunities which was the focus of the present study. Formal policies with regard to cultural sensitivity training for staff may exist to a lesser extent than the actual provision of training opportunities. The five-year time frame between the studies, the different locales, as well as the increasing emphasis upon cultural awareness in academic training and employment settings may also have had an impact on the difference in the findings.

In the present study, there was some discrepancy between organizational planning regarding cultural sensitivity training for staff (identified by only 24% of respondents) and what is actually provided for staff. One possible explanation for this discrepancy is that direct care staff may be requesting and obtaining training in this area despite the lack of plans initiated by the organization. Another possibility is that individual managers may be encouraging this training for their staff without the existence of formal organizational plans. A third possible explanation is that organizations are already providing opportunities for cultural sensitivity training and therefore plans are not needed.

In addition to the areas of linguistic access and staff training, organizational arrangements in other areas of telephone reception and community networking were examined. The utilization of an answering machine in mental health and social services had been previously identified in the literature as a barrier (Orr, Miller, & James, 1984). The continued existence of this barrier was substantiated in the present

study as 89% of the respondents reported that answering machines were used in their organizations. A more positive finding pertaining to organizational arrangements was that the networking practices of mainstream organizations with ethno-specific organizations and with clergy were reported to be adequate for both management and service delivery staff by the vast majority of respondents.

With regard to managerial attitudes, 70% of the respondents identified the system as being responsible for linguistic barriers that reduce access to services by immigrants and refugees. When asked about their beliefs regarding barriers in general, the majority of the respondents (80%) indicated that mental health and social service organizations were the major factor hindering the provision of services to immigrants and refugees. The majority of respondents also reported the beliefs that immigrants and refugees have unique problems related to conveying mental disorders to staff, fear deportation when seeking services, lack abilities in the English language, and distrust mental health agencies.

The majority of the respondents indicated that mental health services for immigrants and refugees in Winnipeg are not adequate. However, there seems to be some interest within the service system in Winnipeg to increase the accessibility of services to immigrants and refugees. Forty-three percent of respondents reported that service providers were "very interested" in working on increased accessibility. However, 47% of the respondents described service providers as only "somewhat interested". This latter finding is more consistent with the tendency of the majority of organizations to not have any actual plans

developed to address accessibility for immigrants and refugees.

In Chapter II, a general conclusion drawn from the literature review was that there is a lack of administrative preparedness by service providers to meet the needs of immigrants and refugees. The descriptive findings of the present study substantiated some of the findings which led to this conclusion, but also provided a more positive view of some aspects of cultural accessibility of mental health and social services. Areas in which inaccessibility of services was substantiated include ethnic representation on organizational boards, the provision of English-only telephone reception, and the use of telephone answering machines. In contrast, the findings pertaining to organizational arrangements with regard to access to interpreters and cultural sensitivity training for staff were more positive than had been reported in previous research. Although there has been a lack of research with regard to the attitudes and beliefs of managerial staff concerning immigrants and refugees, the present findings are positive in that they indicated that the majority of the respondents attributed the responsibility for barriers to the system and organization rather than to the client.

It should be noted there is a range of possible explanations for the more positive nature of some of the findings in the present study including temporal differences, geographical differences, jurisdictional differences, differential informants and differences in definitions. The Doyle and Visano (1987) investigation was completed more than five years ago in Metropolitan Toronto. Supervisory staff were interviewed who represented a wide range of organizations. Access to health and

social services by diverse ethnocultural groups, not just immigrants and refugees, was studied.

A second study, also completed more than five years ago (Quan, 1987), addressed refugee access to mainstream services in Texas by surveying service providers and refugee community leaders. A third study addressing the needs of refugees in Colorado was completed more than five years ago (Coen, 1987). Coen surveyed volunteers and staff in mental health services at the management, direct service, and consultant levels. The latter two studies included respondents from both urban and rural areas.

Since the completion of these three studies, the increasing emphasis placed on multiculturalism in government policies and generally in Canadian society may have contributed to the more positive findings in the present study. In comparison to the two studies in the United States, the present study was confined to an urban area (i.e. Winnipeg). It is possible that service providers in rural areas have less experience in serving immigrants and refugees. Finally, the procedure for selecting the managerial respondents in this study may have resulted in an atypically positive sample (i.e. those interviewed were the most knowledgeable about, or possibly the most interested in, services to immigrants and refugees).

Comparative Findings

There was only one statistically significant difference between respondents from institutional and community based organizations on the comparative questions. This significant finding pertained to one of the three areas of utilization of services that were assessed. Community

based respondents reported significantly higher percentages of immigrants and refugees as present clients than respondents from institutional organizations. This finding is discrepant from previous researchers' descriptions that immigrants, refugees, and visible minorities tend to underutilize community mental health services and are over represented in inpatient populations (Canadian Task Force, 1988a; Cheung & Snowden, 1990). However, it does support the possibility that immigrants and refugees experience greater difficulties in accessing services in large institutions and/or those with multiple specialties (Hoang & Erickson, 1985).

Possible explanations for the divergence between the present and previous research findings relate to both methodological and substantive issues. First of all, there were differences in the definitions of clients and the informant sampling procedures which were utilized. A second possibility is that the institutional organizations in this study differ from those in previous studies in ways that make access to them more difficult. It is also possible that the community based organizations may differ from those in previous studies in ways that make them more accessible. Another possibility is that institutional organizations may utilize means to identify and track immigrant and refugee clients more frequently than community based organizations. However, in the present study no significant differences were obtained between these types of organizations in their means to identify and track immigrant and refugee clients (X^2=0.10, d.f.=1, p=.75) or in their use of intake forms (X^2=1.12, d.f.=1, p=.29). Finally, the wording of the questionnaire in the present study used to differentiate

institutional from community based respondents (i.e. "inpatient", "outpatient") may have been confusing to some respondents. For example, some community based respondents who provide residential care may not have in fact described themselves as providing inpatient services.

Differences pertaining to the other areas of utilization (services provided to immigrants and refugees during the past 10 years and completion of services) were not significant.

There were also several statistically significant differences between organizations from the public sector and the private sector. Respondents from the public sector identified significantly more plans at the service implementation level and more established policies to increase access than respondents from the private sector.

Another finding of the present study was that cultural sensitivity training for staff is being provided in public sector organizations to a significantly greater extent than in private sector organizations. The emphasis placed on multiculturalism in government policies may be placing pressure on public sector organizations to ensure the existence of a culturally aware workforce.

Respondents from the public sector also indicated that they provided bilingual and multilingual telephone receptionist service to a significantly greater degree than respondents from the private sector. This difference may have resulted from the public sector's potentially greater access to financing to increase cultural accessibility and/or adherence to relevant federal and provincial policies, thereby facilitating bilingual and/or multilingual services. In addition, respondents from the public sector reported a significantly higher level

of access to interpreters than respondents from the private sector. Once again, this may relate to differences in accountability for organizations in the public sector, the existence of specific policies, or differences in funding.

Finally, the results indicated that significantly greater interest in increasing accessibility of services was reported by respondents from the public sector than by respondents than from the private sector. This may relate to the presence of government planning initiatives and policies pertaining to multiculturalism resulting in greater interest expressed by respondents in the public sector.

It should also be noted that there were no significant differences between public and private sector respondents in the three areas of utilization measured in the study. Another finding that approached statistical significance was that public sector respondents attributed linguistic barriers to the client, rather than the system, to a greater extent than respondents from the private sector. These two findings suggest that the attempts to deal with barriers in the public sector do not result from more positive attitudes on the part of the public sector managers, but rather to the introduction, and possible enforcement, of government policies. This may also explain the lack of significant differences found regarding the utilization of services by immigrants and refugees between public and private sector respondents.

Hypotheses Findings

Several variables were utilized in the evaluation of each of this study's six hypotheses. This factor made it very difficult to conclude in a general way whether any one hypothesis was confirmed. As a result,

it is most accurate to indicate that five of the six hypotheses were partially confirmed. The sixth one was not confirmed.

Several of the significant findings reported in the present study emphasized the relationship between the presence of planning initiatives and increased access to mainstream mental health and social services by immigrants and refugees. With respect to the first hypothesis, the presence of plans was positively associated with significantly higher percentages of immigrants and refugees as clients, and with higher percentages of services being provided to immigrant and refugee clientele than 10 years ago.

In addition to assessing the impact of the presence of plans in general, four specific types of planning activities were examined as follows: established policies (those considered to be organization-wide and comprehensive), service implementation (refers to changes in staffing and services), staff training, and network/outreach activities. The only specific planning activity that yielded significant findings related to service implementation.

With respect to plans at the service implementation level, the findings supported the relationship of the existence of plans with higher percentages of immigrants and refugees as clients, with higher percentages of services being provided to immigrant and refugee clientele during the past 10 years, and with the proportion of immigrant and refugee clients who complete services. One possible explanation of the findings pertaining to planning is that it in fact leads to greater service utilization by immigrants and refugees, particularly if plans concern the service implementation level. However, another explanation

for the findings is that organizations that have more immigrant and refugee clients may be more likely to plan for them.

As the other three areas of specific types of planning (i.e. established policies, staff training, and network/outreach activities) that were measured had no effect upon utilization of service by immigrants and refugees, it is possible that only changes made by organizations to the delivery of services have any effect. Another possibility is that plans in these three areas are too recent to have had any measurable effect upon utilization. Finally, a more intensive examination of the impact of planning (e.g. face to face interviews, on-site examinations) may have yielded additional information.

Another significant finding relates to service providers' attitudes toward language barriers and accessibility. Service providers who viewed the system as being responsible for the linguistic difficulties with immigrant and refugee clients reported more frequent collaboration between service delivery staff and traditional folk healers than those who view the client as responsible for solving the language problems. It is possible that those who feel that the system is responsible for the language difficulties are more likely to reach out to intermediaries (e.g. traditional folk healers). However, no significant differences were found in the other outreach variables, staff training, or in variables directly relevant to language barriers (i.e. telephone reception in English only, the presence of answering machines, and the use of receptionists between clients and staff). Therefore, it appears more likely that those who have contact with folk healers become convinced that the system should be responsible for

dealing with language barriers. It should be noted that this finding concerning system responsibility for linguistic difficulties and more contact with folk healers only approached statistical significance. As noted previously, however, one of the weaknesses of a cross-sectional survey design is that causal ordering cannot be discerned.

The present study's results were surprising with regard to the benefits of ethnic representation on an organization's board of directors. A significant result was obtained in the opposite direction than was initially hypothesized. Boards which were perceived to have ethnic representation had fewer plans in place at the service implementation level than those organizations that viewed themselves as not having ethnic representation on organizational boards. However, a major limitation in these results must be considered. Ethnic representation on a governing board in this study was all-encompassing, and included individuals from ethnic groups who may have never been immigrants or refugees. Respondents could have described their boards as having ethnic representation and yet, for example, be referring to individuals who are from a visible minority yet born in Canada. Thus the findings do not necessarily relate to boards with immigrants and refugees as members as originally hypothesized. It is also possible that the hypothesis pertaining to ethnic representation on governing boards and planning efforts to reduce barriers was confounded by information about the respondents' level of knowledge regarding the ethnic composition of their communities and boards. This is because the survey question asked the respondent to indicate if the governing board was representative of the community served.

However, possible explanations are warranted if the finding pertaining to plans at the service implementation level is accurate. With respect to other areas of planning, near significant findings indicated that agencies with ethnic board representation are more likely to have plans for comprehensive organizational policies but less likely to have plans to network than those agencies without ethnic representation. These findings may indicate that the efforts of ethnic board members to deal with accessibility issues at the planning level are directed at the organization-wide policy level rather than at service implementation or at networking. It is also possible that networking may be considered unnecessary when boards have ethnic representation. Another explanation for the findings may relate to the use of more informal processes for changes in service implementation and networking by boards with ethnic representation.

Further research in this area needs to be conducted in order to more adequately assess the hypothesis of the positive effects of immigrant and refugee board membership on the reduction of barriers at the planning level. Such research should specifically ask respondents about the presence of immigrants and refugees on their boards rather than about "ethnic representation". In addition, the views of board members could be directly examined.

With respect to organizational arrangements and client tracking, only one finding approached signficance. Organizations that possessed a means to identify immigrants and refugees were found to offer more bilingual and multilingual telephone receptionist services than those without a means of identification. No similar association was found

between the identification of immigrant status on intake forms and multilingual telephone services.

The differences in these two findings may be related to the different nature of the questions on the survey instrument. With respect to a means of identification, respondents were asked whether or not they had a means, but were not asked for further details. Respondents who reported having a means of identification may have thus been referring to the use of intake forms, or to other strategies. Separate data pertaining to the use of intake forms were obtained from a follow-up question in the area of proportions of immigrant and refugee clients. Respondents were asked whether their answers about proportions were based on intake forms or were estimates. They were not asked about identification of immigrant and refugee clients on intake forms in the same manner they were asked more generally about having a means of identication.

The findings indicate that identification of immigrant status may have led to multilingual telephone service, but this seems unlikely as it has not led to decreased use of answering machines, more direct telephone contact with staff, or increased staff training and networking. It appears more likely that multilingual telephone service has led to the identification of immigrant and refugee clients.

The issue of linguistic access to mainstream mental health and social service organizations also yielded significant results. Significantly higher percentages of immigrants and refugees were reported as being part of an organization's client population when organizations had bilingual staff, access to interpreters, and telephone

receptionist service in more than the English language. It is possible that the presence of bilingual staff, interpreters, and multilingual telephone reception lead to greater service utilization by immigrants and refugees, however the opposite causal direction is also possible. It should be noted that a significant amount of the variance in utilization of services is in fact related to the presence of interpreters and bilingual staff.

Although causal relationships cannot be established in this study, organizations should consider the significant associations that were identified. In terms of the implications for organizational practices, organizations may wish to identify the primary language utilized by immigrant and refugee clients and, where feasible, hire bilingual staff accordingly. Access to interpreters could be enhanced by increased networking with ethnocultural community organizations and utilizing services such as centralized language banks. However, access to interpreters may be restricted if fees are involved and additional funding may be required. It should be noted that bilingual staff may be able to serve as interpreters for other staff provided that sufficient flexibility is built into service delivery practices. The issue of multilingual telephone reception may be quite problematic. Since one individual receptionist cannot be expected to be fluent in all languages potentially required by clients, organizations may need to develop specific processes to facilitate the availability of interpretation at reception. Some organizations appear to have addressed the difficulties as multilingual telephone reception was found to be significantly associated with increased proportions of immigrants and refugees as

clients.

The beliefs of service providers also differed significantly with regard to networking efforts undertaken by organization staff. Collaboration between service delivery staff and clergy occurred in organizations to a significantly greater degree when respondents held the belief that immigrants and refugees have difficulties conveying mental disorders to staff. It may be that service delivery staff who feel immigrants and refugees have difficulties conveying symptomatology have more contact with clergy, rather than with traditional folk healers who may not share the service providers' beliefs. However, this does not explain why the belief is not associated with more contact with ethnocultural organizations. It may be that service delivery staff may be more aware of specific clergy to contact, as opposed to having adequate knowledge about traditional folk healers and ethnocultural organizations. The opposite causal direction is also possible, and clergy may, in fact, influence the beliefs of service providers pertaining to immigrants' and refugees' abilities to convey their mental disorders to staff.

A second finding was that significantly more contacts between service delivery staff and ethno-specific organizations were reported to be adequate by respondents who held the belief that immigrants and refugees are distrusting of mental health agencies. One possible explanation for this finding is that increased contacts with ethnocultural organizations at the service delivery level influence the beliefs of service providers pertaining to immigrant and refugee distrust. This may relate to ethnocultural organizations' tendencies to

advocate for immigrants' and refugees' access to mainstream services. Another possible explanation for this finding is that service providers who hold this belief are in contact with ethnocultural organizations in order to generally build trust between mainstream organizations and ethnic communities. In building trust, service providers may find networking with ethnocultural organizations easier as the organizations may be more readily identifiable than traditional folk healers and clergy with regard to specific groups of immigrants and refugees.

A third finding related to networking was that service providers who believed that the lack of a working knowledge of English was a major barrier for immigrants and refugees reported significantly greater use of a telephone receptionist for clients to reach staff. This finding is contrary to what was hypothesized and is of concern since the majority of respondents reported having telephone reception services in only the English language thereby hindering access to services by immigrants and refugees.

One possible explanation for the finding is that organizations that utilize telephone receptionists rather than having clients contact staff directly, become aware that the lack of a working knowledge of English is a major barrier for immigrants and refugees in accessing services. The use of a telephone receptionist may highlight the language difficulties between the organization and client, whereas direct contacts between staff and clients may minimize these difficulties.

Another possible explanation for the finding is that organizations may be training receptionists to be sensitive to cultural and language

barriers, even though they may not be bilingual. Thus, clients who have difficulty communicating in English may not have as much difficulty accessing services through the receptionist. In addition, management may have a better means for assessing the degree to which language barriers are a concern when contacts between staff and clients are made through the receptionist.

Future research pertaining to telephone reception services should include immigrants and refugees as respondents.

Relevance of Findings

Service sectors outside of the mental health and social service organizations might also find these findings of relevance. Other public sector services in areas such as education, housing, health and recreation, as well as private businesses, are also likely experiencing difficulties in the provision of accessible services for immigrants and refugees. When administrative personnel within these other organizations examine their present methods of providing services, some of the significant findings pertaining to the lack of accessibility obtained in this investigation may be helpful. In addition, some of this study's findings pertaining to accessibility for immigrants and refugees may also apply to accessibility of services for <u>all</u> clients. The reduction of organizational barriers faced by immigrants and refugees may well increase accessibility for other clients for whom a given barrier or set of barriers also applies.

The present study provided valuable information that identifies associations between linguistic barriers and organizational planning efforts, and the utilization of services by immigrants and refugees.

Organizational boards and management staff must be encouraged to give priority to examining accessibility issues within their organization and to develop subsequent planning initiatives.

Some caution needs to be utilized, however, when considering this study's findings. It is clear that all of the statistical tests in the investigation are not independent as many of the tests utilized the same variable (e.g. institutional versus community based organizations). Furthermore, some of the variables may be empirically related to each other. Given an alpha level of .05, it would be expected that 5% of the hypotheses would have been supported by chance alone, even if all of the individual hypotheses were unrelated. However, 12% of the hypotheses were confirmed which indicates that the significant findings were not attributable to chance alone.

Future research on accessibility should include an examination of the issue from the perspectives of other stakeholders including direct care personnel, immigrant and refugee clientele, ethno-specific and immigrant serving organizations, policy makers and program sponsors. In addition, further research is needed to more accurately establish the level of need for mental health and social services among immigrants and refugees. This would be of assistance in establishing when services are underutilized and therefore perhaps inaccessible, as well as overutilized. Longitudinal investigations are required in order to establish the causal directions of the findings obtained in the present study. There is also a need to address the confounding variables of this study such as the adequacy of funding for service implementation and the adequacy of mainstream mental health and social services.

Current immigration plans reflect the fact that the future of Canada depends upon a steady increase in the population of immigrants and refugees in the country. There is a necessity on the part of Canadian society to assist in meeting this population's needs, which includes the need for optimal mental health. As Canada is committed to universal health and social programs for all its citizens, increasing the accessibility of mental health and related social services for immigrants and refugees therefore remains an important issue.

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APPENDIX A

ADVANCE LETTER TO RESPONDENT ORGANIZATIONS

August 7, 1991

Dear :

Within the next two weeks, you will be contacted by telephone to participate in a research study. A city-wide survey of mental health service providers is being conducted to examine accessibility of mental health related services by immigrants and refugees. Your organization was selected as an important provider of these types of services.

We would like to interview the management staff whom you feel is most knowledgeable about your agency's services to immigrants and refugees. The telephone survey should only take about 20 to 30 minutes.

In order to ensure confidentiality of survey responses, at the end of the telephone call, the names of the respondent and the agency will be removed from the questionnaire. All completed telephone questionnaires will be destroyed at the completion of the study in the fall of 1991. The names of respondents or their organizations will not be used in any subsequent reports, and specific responses will not be attributable to individual respondents or organizations.

The outcome of this study will be to enhance our understanding of accessibility to mental health services by immigrants and refugees. Your assistance is essential to the study's success. George Nyman, a graduate student with the Child & Family Services Research Group, will be calling to determine if your organization will participate, as well as to get the name of the person to be interviewed.

At the completion of the interview, you will be given an opportunity to indicate whether you would like to receive a copy of the summary of the research findings.

If you have any questions, please contact George Nyman at the Child and Family Services Research Group at 474-6663. Thank you in advance for your cooperation.

Sincerely,

Sid Frankel
Assistant Professor

APPENDIX B

INITIAL LETTER TO ADVISORY GROUP

May 17, 1991

Dear :

Thank you for agreeing to be a member of the advisory group for my research project on immigrant and refugee access to mainstream mental health services in Winnipeg. This letter will provide an overview of the study as well as an outline of the activities of the advisory group.

The objective of the study is to determine the degree to which mainstream mental health services are culturally and linguistically accessible as they relate to service delivery to immigrants and refugees. A telephone survey will be utilized with providers of these services in order to examine issues (e.g. barriers) pertaining to accessibility. The outcome of the study will be to provide information about the current level of accessibility and the directions needed for enhancing service delivery to this population.

The role of the advisory group is to assist in the following areas:

-verify barriers to service delivery that have been noted in the research literature

-identify any additional barriers that are felt to exist

-assist in developing specific questions for the telephone survey

-provide interpretation of the collective data obtained from the respondents

I will provide you with information to address each of the above tasks. The time that will be required of you will be minimized as much as possible.

Initially, I would like to have a meeting with all members of the advisory group in order to address questions related to the study, as well as, commence the various tasks. If a meeting with all of the group members is not possible I will meet individually with those individuals who were unable to attend. I am hoping to administer the telephone survey in late June or early July, 1991.

At some point over the summer, I would also like to meet (if possible) with each of the advisory members to elicit various interpretations of the collective data obtained from the telephone respondents.

I appreciate your interest and willingness to contribute your time and expertise to this project. I will be contacting you in the next few weeks to arrange a time for our meeting. In the meantime, if you have any questions please feel free to contact me at 786-7841 or 489-0038.

Yours sincerely,

George A. Nyman
MSW Graduate Student

APPENDIX C: TELEPHONE SURVEY INSTRUMENT

TELEPHONE SURVEY OF PROVIDERS OF MAINSTREAM MENTAL HEALTH SERVICES

Organization:_____

Name:_____ Designate Name:_____

Title:_____ Title:_____

Phone #:_____ Phone #:_____

Address_____

This is George Nyman from the Child and Family Services Research Group, Faculty of Social Work, at the University of Manitoba. A letter was recently sent to you requesting your involvement in a survey to examine accessibility of mental health and social services by immigrants and refugees. (GO TO PAGE 2)

Date	Time	Results	Recall Code

Abreviations:

NA = No answer

WNA = Was not available

WR = Will return (when)

WN = Wrong number

RE = Recontact

SC = Survey Completed

PC = Partially Completed

REF = Refused (when, why)

CNM = Criteria not met

NLE = No longer exists

(CIRCLE THE FOLLOWING)

Send Copy of Results

NO.....1
YES.....2

Final Status:
1 = SC
2 = PC
3 = REF
4 = CNM
5 = NL

Time: Start _____ Finish _____

Did you receive my letter?

NO.....1

(OFFER TO REVIEW CONTENTS OF LETTER) Would you be willing to participate in the survey?

NO.....1
YES.....2

YES.....2

As you are aware, the survey should take about 20 to 30 minutes and your participation is voluntary. Would you be willing to participate in the survey?

NO.....1
YES.....2

NO.....1
YES.....2

Do you have a few minutes now? (IF NO, ASK FOR RECONTACT TIME). Before we begin I would like to ask you a few questions about your organization.

(A) Do you offer mental health or social services in:

Assessment
NO.....1
YES.....2

Counselling or Treatment
NO.....1
YES.....2

(B) Do paid staff provide these services to your client population?

NO.....1
YES.....2

(IF NO TO A OR B ABOVE) Thank you for your help but I am only surveying organizations that hire staff who provide assessment, counselling and/or treatment services.

(C) Do you provide these services to more than one ethnic population?

NO.....1
YES.....2

(IF NO TO C ABOVE) Thank you for your help but I am surveying organizations that provide services to the general public.

(IF NO, DEAL WITH RESPONDENT'S CONCERNS, E.G.: Use Respondent Question Sheet)

(IF NO, OBTAIN REASONS AND CONSIDER AS REFUSED)

1 = Not interested
2 = Concerns of confidentiality
3 = Other

I would like to begin with your opinion on barriers to mental health services to immigrants and refugees. Researchers have identified a range of obstacles that impede accessibility to this population.

1. Which of the following 3 barriers do you believe is the most responsible for hindering an immigrant's and refugee's access to services at a mainstream mental health and social service organization?

STAFF BEING UNABLE TO SPEAK THE PRIMARY LANGUAGE OF THE IMMIGRANT CLIENT.....1

THE LACK OF INTERPRETERS AT THE ORGANIZATION.....2

THE IMMIGRANT CLIENT NOT BEING ABLE TO SPEAK ENGLISH.....3

(Don't know).....8
(Refusal).....9
(Slip up).....0

2. What barriers do you believe are the most impeding to providing services to this population?

3. I would now like to get your viewpoint on the terms immigrant and refugee.

3.1 How do you define immigrant?

3.2 How about the term refugee?

4. Which of the following five service providers do you believe an immigrant and refugee would approach first to get help for their mental health related problems?

		(1) FIRST	(2) SECOND
4.1	MENTAL HEALTH CENTRE/HOSPITAL	_____	_____
	ETHNOSPECIFIC ORGANIZATION	_____	_____
	FAMILY DOCTOR	_____	_____
	CLERGY/CHURCHES	_____	_____
	TRADITIONAL FOLK HEALERS	_____	_____
	(Don't Know)	_____	_____
	(Refusal)	_____	_____
	(Slip Up)	_____	_____

4.2 Which provider would be their second choice?

5. How interested do you believe that mental health service providers in Winnipeg are on working to increase accessibility of services to immigrants and refugees?

NOT REALLY INTERESTED.....1
SOMEWHAT INTERESTED.....2
VERY INTERESTED.....3
VERY INTERESTED AND WILLING TO DIALOGUE WITH OTHER SERVICE PROVIDERS.....4
(Don't Know).....8
(Refused).....9
(Slip Up).....0

6. When compared to other mainstream mental health services in Winnipeg, to what extent are your services culturally accessible?

MUCH LESS THAN OTHER SERVICES.....1
SOMEWHAT LESS THAN OTHER SERVICES.....2
THE SAME AS OTHER SERVICES.....3
SOMEWHAT BETTER THAN OTHER SERVICES.....4
MUCH BETTER THAN OTHER SERVICES.....5
(Don't Know).....8
(Refusal).....9
(Slip up).....0

7. What difficulties would your organization confront in making your services more culturally accessible?

For the purposes of this study, we have defined "immigrants and refugees" as follows:

> Any individuals who have entered Canada during the past decade under any of the three immigration classes of family class, independent immigrants, and refugees as specified by Immigration Canada. These persons would have not spoken English or French at the time of their immigration to Canada. Furthermore, individuals whose classification had not yet been determined by Immigration Canada, such as a claimant, would also be considered for inclusion into this definition.

8. Using this definition what percentage of your present client population would you consider to be immigrants and refugees?

(DO NOT READ)

8.1

0%.....1
1-10%.....2
11-30%.....3
31-50%.....4
over 50%.....5
(Don't Know)...8
(Refusal).....9
(Slip Up).....0

8.2 → Is this information asked on intake forms or is this your estimate?

Intake forms...1
Estimate.....2
Other.....3

9. During the past 10 years would you say the percentage of your client services to immigrants and refugees have

DECREASED.....1
STAYED THE SAME.....2
INCREASED SOMEWHAT.....3
INCREASED SIGNIFICANTLY...4
(Don't Know).....8
(Refused).....9
(Slip Up).....0

10. How have your client services changed to meet the needs of immigrants and refugees?

11. Does your organization have established policies to improve access to your services by immigrants and refugees?

NO.....1
BEING CONSIDERED..2
BEING DEVELOPED...3
YES.....4
(Don't Know)...8
(Refused).....9
(Slip Up).....0

12. What specific plans has your organization developed to improve access to services by immigrants and refugees?

12.1 Have any of these plans been implemented?

NO.....1
YES.....2
(Don't Know).....8
(Refused).....9
(Slip Up).....0

12.2 → Have they been evaluated?

NO.....1
YES.....2
(Don't Know).....8
(Refused).....9
(Slip Up).....0

12.3 → What were the results of your evaluation?

13. Does your organization have a means of determining whether your clients are immigrants and refugees?

NO.....1
YES.....2
(Don't Know).....8
(Refused).....9
(Slip Up).....0

13.1 → Why doesn't your organization track this information?

13.2 → What are the nationalities of the immigrants and refugees that you serve?

13.3 → Over the past year, what % of the immigrants you served were

MALE _____
FEMALE _____
(Don't Know).....8
(Refused).....9
(Slip Up).....0

13.4 → During the past year what % were

0-18 YEARS _____
19-65 YEARS _____
OVER 65 _____
(Don't Know).....8
(Refused).....9
(Slip Up).....0

13.5 → Can you estimate the % of immigrants who actually complete the services that they started at your agency?

(Don't Know).....8
(Refused).....9
(Slip Up).....0

14. What types of services do you provide to the general public?

14.1 Are any of these services more difficult to provide to immigrants and refugees?

NO.....1
YES.....2
(Don't Know).....8
(Refused).....9
(Slip Up).....0

14.2 → Which of these services are more difficult to provide?

14.3 → Are there any reasons that can help explain these difficulties?

15. Are there any direct monetary costs to clients in order to receive your services?

NO.....1
YES.....2

16. What % of your staff that provide mental health and social services would you consider being bilingual?

(DO NOT READ)

0-33%.....1
34-67%.....2
67-100%.....3
(Don't Know).....8
(Refused).....9
(Slip Up).....0

17. Do you have ready access to qualified interpreters to assist you in your work with immigrants and refugees?

NO.....1
SOMETIMES.....2
MOST OF THE TIME...3
ALWAYS.....4
(Don't Know).....8
(Refusal).....9
(Slip Up).....0

17.1 → Which of the following languages are interpreters available?

	(1) NO	(2) YES	(8) DON'T KNOW	(9) REFUSE	(0) SLIP UP
TAGALOG					
POLISH					
CANTONESE					
VIETNAMESE					
PORTUGUESE					
SPANISH					
LAOTIAN					
HINDI					
OTHER					

17.2 → How are these interpreters selected and trained?

17.3 → Are these interpreters available at the stage of:

	(1) NO	(2) YES	(8) DON'T KNOW	(9) REFUSE	(0) SLIP UP
Intake					
ASSESSMENT					
COUNSELLING/ TREATMENT					
FOLLOW-UP					

17.4 → Using the following scale, how important are language interpreters in providing your services to immigrants and refugees?

NOT IMPORTANT.....1
OF SOME IMPORTANCE.....2
OF GREAT IMPORTANCE.....3
(Don't Know).....8
(Refusal).....9
(Slip Up).....0

18. I would also like to address several organizational arrangements.

Using the following scale of never, sometimes, often, and always please specify the degree to which the following descriptions pertain to your organization.

	1 NEV	2 SOM	3 OFT	4 ALW	8 DK	9 R	0 SU
1. EDUCATIONAL AND TRAINING OPPORTUNITIES ARE PROVIDED TO STAFF ON CULTURAL SENSITIVITY.	___	___	___	___	___	___	___
2. YOUR AGENCY'S MANAGEMENT LEVEL HAS BEEN ABLE TO ADEQUATELY NETWORK WITH ETHNOSPECIFIC ORGANIZATIONS IN THE COMMUNITY YOU SERVE.	___	___	___	___	___	___	___
3. YOUR AGENCY'S SERVICE DELIVERY PERSONNEL HAS BEEN ABLE TO ADEQUATELY NETWORK WITH ETHNOSPECIFIC ORGANIZATIONS IN THE COMMUNITY YOU SERVE	___	___	___	___	___	___	___
4. SERVICE DELIVERY STAFF GENERALLY COLLABORATE WITH CLERGY WHO KNOW THE IMMIGRANT CLIENT.	___	___	___	___	___	___	___
5. SERVICE DELIVERY STAFF GENERALLY COLLABORATE WITH TRADITIONAL FOLK HEALERS WHO KNOW THE IMMIGRANT CLIENT.	___	___	___	___	___	___	___
6. TELEPHONE RECEPTION IS PROVIDED IN ONLY THE ENGLISH LANGUAGE.	___	___	___	___	___	___	___
7. AN ANSWERING MACHINE IS USED AT YOUR ORGANIZATION.	___	___	___	___	___	___	___
8. CLIENTS REACH STAFF BY GOING THROUGH THE TELEPHONE RECEPTIONIST.	___	___	___	___	___	___	___

19. Would you say the ethnic background of your governing board is representative of the community you serve?

NO.....1
YES.....2
(Don't Know).....8
(Refused).....9
(Slip Up).....0

20. With regards to ethnic background of board members, how does your organization recruit and orient these individuals?

21. At intake do you request information from the client on his/her:

21.1	-ETHNIC BACKGROUND	NO.....1 YES.....2 (Don't Know).....8 (Refused).....9 (Slip Up).....0
21.2	-LANGUAGES SPOKEN	NO.....1 YES.....2 (Don't Know).....8 (Refused).....9 (Slip Up).....0

22. What would an intake worker do if the client did not speak English?

23. What sources in the community do you refer immigrants and refugees who are having mental health related problems?

(DO NOT READ; CIRCLE ONLY)

MENTAL HEALTH CENTRE/HOSPITAL.....1
FAMILY DOCTOR.....2
ETHNOSPECIFIC ORGANIZATION.....3
IMMIGRANT ACCESS SERVICE.....4
CLERGY/CHURCHES.....5
TRADITIONAL FOLK HEALERS.....6
COMMUNITY MENTAL HEALTH SERVICE.....7
PRIVATE PRACTITIONERS.....
  PSYCHIATRISTS.....
  PSYCHOLOGISTS.....
  SOCIAL WORKERS.....
SOCIAL SERVICE AGENCY.....
OTHER.....
(Don't Know).....8
(Refused).....9
(Slip Up).....0

24. Would you jot down the following categories on a piece of paper: strongly disagree, mildly disagree, neither agree or disagree, mildly agree, and strongly agree. I would now like to ask you how you feel about the following statements using these categories for your responses.

1. Immigrants and refugees have difficulty conveying sensations of mental disorder to mental health staff.

STRONGLY DISAGREE.....1
MILDLY DISAGREE.....2
NEITHER AGREE OR DISAGREE.....3
MILDLY AGREE.....4
STRONGLY AGREE.....5
(Don't Know).....8
(Refused).....9
(Slip Up).....0

2. Immigrants and refugees do not seek mental health services as they fear this may lead to possible deportation.

STRONGLY DISAGREE.....1
MILDLY DISAGREE.....2
NEITHER AGREE OR DISAGREE.....3
MILDLY AGREE.....4
STRONGLY AGREE.....5
(Don't Know).....8
(Refused).....9
(Slip Up).....0

3. An immigrant's lack of working knowledge of the English language is a major barrier to service delivery.

STRONGLY DISAGREE.....1
MILDLY DISAGREE.....2
NEITHER AGREE OR DISAGREE.....3
MILDLY AGREE.....4
STRONGLY AGREE.....5
(Don't Know).....8
(Refused).....9
(Slip Up).....0

4. Immigrants and refugees are distrusting of mental health agencies.

STRONGLY DISAGREE.....1
MILDLY DISAGREE.....2
NEITHER AGREE OR DISAGREE.....3
MILDLY AGREE.....4
STRONGLY AGREE.....5
(Don't Know).....8
(Refused).....9
(Slip Up).....0

5. The lack of interpreters at mental health organizations is a major barrier to service delivery to immigrants and refugees.

STRONGLY DISAGREE.....1
MILDLY DISAGREE.....2
NEITHER AGREE OR DISAGREE.....3
MILDLY AGREE.....4
STRONGLY AGREE.....5
(Don't Know).....8
(Refused).....9
(Slip Up).....0

6. The mainstream mental health services provided to immigrants and refugees in Winnipeg are adequate enough to meet this populations needs.

STRONGLY DISAGREE.....1
MILDLY DISAGREE.....2
NEITHER AGREE OR DISAGREE.....3
MILDLY AGREE.....4
STRONGLY AGREE.....5
(Don't Know).....8
(Refused).....9
(Slip Up).....0

25. If additional funding was available to mainstream mental health and social service providers to assist them in increasing accessibility to services to immigrants and refugees, how would your organization use the extra monies?

We are near the end of the survey and would appreciate some information about your organization for interpretive purposes.

26. What are the funding arrangements for your organization?

GOVERNMENT (FED./PROV.) FUNDED.....1
MUNICIPALLY FUNDED.....2
PRIVATELY FUNDED.....3
CHARITABLE DONATIONS.....4
OTHER.....5
(Don't Know).....8
(Refused).....9
(Slip Up).....0

27. How many clients does your organization provide service to on a yearly basis?

LESS THAN 100.....1
101 TO 500.....2
501 TO 1000.....3
OVER 1000.....4
(Don't Know).....8
(Refused).....9
(Slip Up).....0

28. Which of the following age ranges of clients do you provide services?

0 to 18 years.....1
19 to 65 years.....2
over 65 years.....3
no age limit.....4
(Refused).....9
(Slip Up).....0

29. Using the following scale, how many professional staff are employed at your organization?

LESS THAN 10.....1
10 TO 30.....2
31 TO 100.....3
OVER 100.....4
(Don't Know).....8
(Refused).....9
(Slip Up).....0

30. How many volunteers work at your organization?

LESS THAN 10.....1
10 TO 30.....2
31 TO 100.....3
OVER 100.....4
(Don't Know).....8
(Refused).....9
(Slip Up).....0

31. The types of services provided by your organization include

INPATIENT.....1
OUTPATIENT.....2
BOTH.....3
(Don't know).....8
(Refused).....9
(Slip up).....0

Finally, I would like to ask you a few questions about yourself for statistical purposes.

32. (Sex of respondent: MALE.....1
FEMALE.....2)

33. Given the following age ranges, what is your present age?

UNDER 30 YEARS.....1
31 TO 50 YEARS.....2
OVER 50 YEARS.....3
(Refusal).....9
(Slip Up).....0

34. What is your country of birth?

(Do not read; Circle Only)
CANADA.....1
UNITED STATES.....2
UNITED KINGDOM.....3
PHILIPPINES.....4
POLAND.....5
VIETNAM.....6
OTHER.....7
(Refusal).....9
(Slip Up).....0

35. What is your highest academic degree?

(Do Not Read; Circle Only)
HIGH SCHOOL DIPLOMA.....1
NON-DEGREE CERTIFICATE.....2
COMMUNITY COLLEGE (2 YEARS)...3
SOME UNIVERSITY.....4
BACHELOR'S DEGREE.....5
MASTER'S DEGREE.....6
DOCTORATE DEGREE.....7

(Refused).....9
(Slip Up).....0

36. Do you have any specific suggestions that would assist other mental health organizations in making their services more accessible to immigrants and refugees that reside in Winnipeg?

37. This study will be completed later this fall. Would you like a summary report of the survey findings?

NO.....1
YES.....2

Thank you for your assistance in the completion of this survey. It was very much appreciated.

Time Finish _____
****

TO GEORGE: (RATE THE INTERVIEW)

In general, how well did the interview go?

NOT WELL.....1
SO-SO.....2
WELL.....3
VERY WELL.....4

NOTE: SEE MASTER LIST AND FRONT PAGE RE: SENDING SUMMARY REPORT

****

APPENDIX D

MISSING CASES PER VARIABLE

(N=85)

Variable	No. of missing cases[a]	No. not applicable[b]	Percentage of cases missing[c]
Utilization and tracking			
% of immigrants/refugees as clients	7	0	8
Intake forms or estimate	0	8	0
Services to immigrants/refugees (10 years)	6	0	7
Means to identify immigrant/refugee	0	0	0
% of immigrant/refugee clients who complete services	20	42	47
Interpreters[d]			
Access to interpreters	1	0	1
Interpretation in Tagalog	12	14	17
Interpretation in Polish	7	14	10
Interpretation in Cantonese	14	14	20
Interpretation in Vietnamese	7	14	10
Interpretation in Portugese	9	14	13
Interpretation in Spanish	7	14	10
Interpretation in Laotian	15	14	21
Interpretation in Hindi	20	14	28
Interpretation in other languages	5	14	7
Organizational arrangements			
Training for staff	1	0	1
Network: management and ethnocultural organizations	1	0	1
Network: service staff and ethnocultural organizations	0	0	0
Staff collaborate with clergy	3	0	4
Staff collaborate with traditional folk healers	3	0	4
Telephone in English only	0	0	0
Answering machine used	0	0	0
Telephone reception to reach staff	0	0	0
Policies to increase access	3	0	4
% of bilingual staff	4	0	5
Ethnic representation on board	3	10	4

Table continues

Variable	No. of missing cases[a]	No. not applicable[b]	Percentage of cases missing[c]
Attitudes			
Language barrier most responsible	6	0	7
Beliefs			
System interest to increase access	4	0	5
Convey mental disorder to staff	0	0	0
Fear of deportation	0	0	0
Lack of English barrier	1	0	1
Distrust of mental health services	0	0	0
Lack interpreters barrier	0	0	0
Adequacy of mental health services	0	0	0
Funding			
Government	0	0	0
Municipal	0	0	0
Private	0	0	0
Charitable	0	0	0
Other	0	0	0
Organization/respondent characteristics			
Professional staff at organization	0	0	0
Volunteers at organization	2	0	2
Type of services	2	0	2
Sex of respondent	0	0	0
Age of respondent	0	0	0
Birthplace of respondent	0	0	0
Highest academic training	0	0	0
Barrier (inductive)			
Society	0	0	0
Systec	0	0	0
Organization	0	0	0
Client	0	0	0
Definition (inductive)			
Immigrant	0	0	0
Refugee	0	0	0
Difficulties to increase access (inductive)			
Planning	1	0	1
Service implementation	1	0	1
Evaluation	1	0	1
Attitudes	1	0	1

Table continues

Variable	No. of missing cases[a]	No. not applicable[b]	Percentage of cases missing[c]
Plans			
Plans to increase access	0	0	0
Plans implemented	0	47	0
Plans evaluated	1	47	3
Plans (inductive)			
Established policies	0	0	0
Staff/service changes	0	0	0
Staff training	0	0	0
Networking/outreach	0	0	0
Evaluation (inductive)			
Policies	0	83	0
Staff/service changes	2	65	10
Staff training	1	76	11
Networking/outreach	2	65	10
Hypothetical funding			
Planning	3	0	4
Service implementation	3	0	4
Evaluation	3	0	4
Attitudes	3	0	4

[a]Includes "Do not know" and "Refused" responses.

[b]Includes "Does not apply" and "Screened out" responses.

[c]Refers to "Do not know" and "Refused" responses. Percentage is based on applicable cases.

[d]Several respondents answered "Do not know" with regard to having access to interpreters for some specific languages.

APPENDIX E

MISSING VARIABLES PER CASE

(N=85)

No. of variables missing per case[a]	Frequency	Percentage of total applicable variables missing[b]
0	10	11.8
1	26	30.6
2	11	12.9
3	17	20.0
4	6	7.1
5	4	4.7
6	4	4.7
7	3	3.5
8	3	3.5
19	1	1.2

Total number of variables=73

M=2.72; *SD*=2.75; *R*=19

Note. Several respondents answered "Do not know" with regard to having access to interpreters for some specific languages.

[a]Includes "Do not know" and "Refused" responses.

[b]Refers to "Do not know" and "Refused" responses.